Hemodialysekateter – tilkobling og frakobling

Kvalitetsvurdert kunnskapsgrunnlag
Oppsummert forskning
Systematiske oversikter
Kvalitetsvurderte enkeltstudier
Pasientinformasjon

Sannsynligvis OK kunnskapsgrunnlag
Pasientinformasjon

Kunnskapsgrunnlaget må kvalitetsikres
Pasienterfaringer
Retningslinjer
Enkeltstudier

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OPPSUMMERT FORSKNING

Helsedirektoratet
Ingen funn

Nasjonalt nettverk for fagprosedyrer

Sentralt venekateter (SVK) – Stell og bruk av tunnelert og ikke-tunnelert kateter hos voksne Ny!

Vårdhandboken
Basala hygienrutiner och klädregler Ny!

Dialys, hemodialys

Central venkateter

NHS NICE Pathways
Ingen funn

Nursing Reference Center

Quick Lessons:

Ingen funn

Skills:

Hemodialysis Site Care: Performing NY!
Hemodialysis Site Care: Performing (checklist) NY!
Central Venous Catheter Care: Lumen—Flushing NY!
Central Venous Catheter Care: Changing Dressings (checklist) NY!

Evidence-Based Care Sheets:

Renal Failure, End-Stage: Hemodialysis and Quality of Life NY!

CE (Continuing Education for Nurses):

Hemodialysis Catheter Outcomes Pilot Study: No Dressing Coverage With Prescribed Showering. NY!
Infection Control and Bloodstream Infection Prevention: The Perspective Of Patients Receiving Hemodialysis. NY!
Hemodialysis Stressors and Coping Strategies Among Jordanian Patients On Hemodialysis: A Qualitative Study. NY!
Shower and No-Dressing Technique For Tunneled Central Venous Hemodialysis Catheters: A Quality Improvement Initiative. NY!
CNE: Continuing Nursing Education. Hemodialysis catheter care: current recommendations for nursing practice in North America... [corrected] [published errata appear in NEPHROL NURS 2011 Jul/Aug;38(4):377]. NY!
Clinical and cost effectiveness of guidelines to prevent intravascular catheter-related infections in patients on hemodialysis. NY!
Quality of life in patients undergoing hemodialysis and renal transplantation—a meta-analytic review. NY!
Factors affecting quality of life in persons on hemodialysis. NY!
Preventing Catheter-Associated Bloodstream Infections in Hemodialysis Centers: The Facility Perspective. NY!
CNE: Continuing Nursing Education. A practical review of the Kidney Dialysis Outcomes Quality Initiative (KDOQI) guidelines for hemodialysis Catheters and Their Potential Impact On Patient Care. NY!

National Guideline Clearinghouse

Guidelines for the prevention of intravascular catheter-related infections, 2011. NY!
NKF-K/DOQI clinical practice guidelines for hemodialysis adequacy: update 2006. National Kidney Foundation. NGC:005329

Kliniske retningslinjer, Danmark

Klinisk retningslinje for pleje og håndtering af centralt venekateter og permanent central intravenøs port hos voksne (>19 år) patienter

NHS NICE Guidelines
Ingen funn

SIGN, Scottish Intercollegiate Guideline Network
Ingen funn

Socialstyrelsen, Sverige
Ingen funn

Sundhedsstyrelsen, Danmark
Ingen funn

UpToDate
Overview of central catheters for acute and chronic hemodialysis access NY!
Antibiotic lock therapy for treatment of catheter-related bloodstream infections NY!
Technical aspects of nocturnal hemodialysis NY!

Treatment and prevention of Acinetobacter infection
Chronic hemodialysis vascular access: Types and placement
Acute hemodialysis vascular access
Tunneled, cuffed hemodialysis catheter-related bacteremia
Thrombosis associated with chronic hemodialysis vascular access: Catheters
Overview of the treatment of stenosis and thrombotic complications of hemodialysis arteriovenous grafts and fistulas
Prevention of intravascular catheter-related infections
Central vein stenosis associated with dialysis access
Air Embolism

Clinical Evidence
End-stage renal disease

BMJ Best Practice
Chronic renal failure

SYSTEMATISKE OVERSIKTER

Cochrane Reviews
Ultrasound use for the placement of haemodialysis catheters NY!
Anticoagulants and antiplatelet agents for preventing central venous haemodialysis catheter malfunction in patients with end-stage kidney disease NY!
Antimicrobial lock solutions for preventing catheter-related infections in haemodialysis NY!

Pre-emptive correction for haemodialysis arteriovenous access stenosis NY!
Preoperative vascular access evaluation for haemodialysis patients NY!

Interventions for preventing infectious complications in haemodialysis patients with central venous catheters NY!

DARE

A meta-analysis of hemodialysis catheter locking solutions in the prevention of catheter-related infection (Structured abstract) NY!
Systematic review and meta-analysis on management of hemodialysis catheter-related bacteremia (Provisional abstract) NY!
Meta-analysis: antibiotics for prophylaxis against hemodialysis catheter-related infections (Structured abstract) NY!
Antimicrobial lock solutions for the prevention of infections associated with intravascular catheters in patients undergoing hemodialysis : systematic review and meta-analysis of randomized, controlled trials (Structured abstract) NY!
Does warfarin safely prevent clotting of hemodialysis catheters: a review of efficacy and safety (Structured abstract) NY!
Antiplatelet medications in hemodialysis patients: a systematic review of bleeding rates (Structured abstract) NY!
Associations between hemodialysis access type and clinical outcomes: a systematic review (Provisional abstract) NY!
Use of real-time ultrasound guidance for the placement of hemodialysis catheters: a systematic review and meta-analysis of randomized controlled trials (Provisional abstract) NY!
Citrate versus heparin lock for hemodialysis catheters: a systematic review and meta-analysis of randomized controlled trials (Provisional abstract) NY!
Ultrasound monitoring to detect access stenosis in hemodialysis patients: a systematic review (Structured abstract) NY!

McMaster PLUS

Buttonhole versus rope-ladder cannulation of arteriovenous fistulas for hemodialysis: a systematic review.(Systematic Review) NY!
Citrate versus heparin lock for hemodialysis catheters: a systematic review and meta-analysis of randomized controlled trials.(Systematic Review) NY!
Buttonhole cannulation and clinical outcomes in a home hemodialysis cohort and systematic review.(Systematic Review) NY!
Vascular access for intensive maintenance hemodialysis: a systematic review for a Canadian Society of Nephrology clinical practice guideline.(Systematic Review) NY!
Associations between hemodialysis access type and clinical outcomes: a systematic review.(Systematic Review) NY!
Central venous access sites for the prevention of venous thrombosis, stenosis and infection.(Systematic Review) NY!
Use of real-time ultrasound guidance for the placement of hemodialysis catheters: a systematic review and meta-analysis of randomized controlled trials.(Systematic Review) NY!
Ultrasound use for the placement of haemodialysis catheters.(Systematic Review) NY!
Efficacy, safety, and cost of thrombolytic agents for the management of dysfunctional hemodialysis catheters: a systematic review.(Systematic Review) NY!
Antiplatelet agents for the prevention of arteriovenous fistula and graft thrombosis: a meta analysis.(Systematic Review) NY!
Interventions for preventing infectious complications in haemodialysis patients with central venous catheters.(Systematic Review) NY!
Antiplatelet medications in hemodialysis patients: a systematic review of bleeding rates.(Systematic Review) NY!
Nonmaturation of arm arteriovenous fistulas for hemodialysis access: A systematic review of risk factors and results of early treatment.(Systematic Review) NY!
Ultrasound monitoring to detect access stenosis in hemodialysis patients: a systematic

review.(Systematic Review) NY!
Meta-analysis: antibiotics for prophylaxis against hemodialysis catheter-related infections.(Systematic Review) NY!
A meta-analysis of hemodialysis catheter locking solutions in the prevention of catheter-related infection.(Systematic Review) NY!
Systematic review of the effectiveness of preventing and treating Staphylococcus aureus carriage in reducing peritoneal catheter-related infections.(Systematic Review) NY!

PEDro
Ingen funn

OT Seeker
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Kunnskapssenteret
Ingen funn

Campbell Library
Ingen funn

KVALITETSVURDERTE ENKELTSTUDIER

Evidence-Based Nursing
Ikke søkt her

Evidence-Based Medicine
Ikke søkt her

Evidence-Based Mental Health
Ikke søkt her

Evidence-Based Dentistry
Ikke søkt her

McMaster PLUS
Ikke søkt her

EHS Protocols
Ikke søkt her

PASIENTINFORMASJON

Nasjonalt nettverk for fagprosedyrer

Pasientmedvirkning på individnivå

Vårdhandboken
Bemötande i vård och omsorg, genusperspektiv
Bemötande i vård och omsorg, patientperspektiv
Bemötande i vård och omsorg, transkulturellt perspektiv
Bemötande i vård och omsorg, HBT-perspektiv
Bemötande av personer med funktionsnedsättning

Personcentrerad vård

NHS NICE Pathways

Patient experience in adult NHS services overview

UpToDate
Ingen funn

BMJ Best Practice
Ingen funn

Nursing Reference Center
Hemodialysis NY!

PASIENTINFORMASJON

OBS! Mest sannsynlig god kvalitet.

Sykehuset Innlandet
Dialysebehandling (Lillehammer) NY!

Helsenorge
Kronisk nyresykdom NY!

Helsebiblioteket
Ingen funn

NEL, Norsk elektronisk legehåndbok
Kronisk nyresykdom, behandling NY!
Nyredialyse NY!
Kronisk nyresvikt NY!
Akutt nyresvikt, behandling NY!
Kronisk nyresykdom, oversikt NY!
Kronisk nyresykdom, årsaker NY!
Kronisk nyresykdom, symptomer NY!
Kronisk nyresykdom, undersøkelser NY!

Kronisk nyresykdom, prognose NY!

MedlinePLUS
Hemodialysis Catheters: How to Keep Yours Working Well NY!
What You Should Know about Infectious Diseases: A Guide for Hemodialysis Patients and Their Families NY!
Coping Effectively: A Guide to Living Well with Kidney Failure NY!
Living with Kidney Disease: Frequently Asked QuestionsKidney Failure: Choosing a Treatment That's Right for You NY!
Hemodialysis NY!
Take Steps to Keep Your Heart Healthy on Dialysis NY!
Your Dialysis Care Team NY!
Filtering Dialysis Myths from Facts NY!
Dietary Guidelines for Adults Starting on Hemodialysis NY!
Dialysis - hemodialysis NY!
Treatment Methods for Kidney Failure: Hemodialysis NY!
What's the Deal with Dialysis? NY!
Eat Right to Feel Right on Hemodialysis NY!
Exercise: A Guide for People on Dialysis NY!

Nasjonalt informasjonssenter for alternativ medisin
Ingen funn

Norsk helseinformatikk
Kronisk nyresykdom, behandling NY!
Nyredialyse NY!
Kronisk nyresvikt NY!
Akutt nyresvikt, behandling NY!
Kronisk nyresykdom, oversikt NY!
Kronisk nyresykdom, årsaker NY!
Kronisk nyresykdom, symptomer NY!
Kronisk nyresykdom, undersøkelser NY!
Kronisk nyresykdom, prognose NY!

TIPS! På nettsiden Sunn skepsis forklares det hvordan pasientinformasjon skal kvalitetvurderes.

PASIENTERFARINGER

OBS! Må kvalitetvurderes.

Medline

Pasienterfaringer MEDLINE

1. Patients' perspectives on hemodialysis vascular access: a systematic review of qualitative studies. [Review] Casey JR; Hanson CS; Winkelmayer WC; Craig JC; Palmer S; Strippoli GF; Tong A. American Journal of Kidney Diseases. 64(6):937-53, 2014 Dec. [Journal Article. Research Support, Non-U.S. Gov't. Review] UI: 25115617

BACKGROUND: Delayed creation of vascular access may be due in part to patient refusal and is associated with adverse outcomes. Concerns about vascular access are prevailing treatment- related stressors for patients on hemodialysis therapy. This study aims to describe patients' perspectives on vascular access initiation and maintenance in hemodialysis. STUDY DESIGN: Systematic review and thematic synthesis of qualitative studies. SETTING & POPULATION: Patients with chronic kidney disease who express opinions about vascular access for hemodialysis. SEARCH STRATEGY & SOURCES: MEDLINE, EMBASE, PsycINFO, CINAHL, reference lists, and PhD dissertations were searched to October 2013. ANALYTICAL APPROACH: Thematic synthesis was used to analyze the findings. RESULTS: From 46 studies involving 1,034 patients, we identified 6 themes: heightened vulnerability (bodily intrusion, fear of cannulation, threat of complications and failure, unpreparedness, dependence on a lifeline, and wary of unfamiliar providers), disfigurement (preserving normal appearance, visual reminder of disease, and avoiding stigma), mechanization of the body (bonded to a machine, internal abnormality, and constant maintenance), impinging on way of life (physical incapacitation, instigating family tension, wasting time, and added expense), self-preservation and ownership (task-focused control, advocating for protection, and acceptance), and confronting decisions and consequences (imminence of dialysis therapy and existential thoughts). LIMITATIONS: Non-English articles were excluded. CONCLUSIONS: Vascular access is more than a surgical intervention. Initiation of vascular access signifies kidney failure and imminent dialysis, which is emotionally confronting. Patients strive to preserve their vascular access for survival, but at the same time describe it as an agonizing reminder of their body's failings and "abnormality" of being amalgamated with a machine disrupting their identity and lifestyle. Timely education and counseling about vascular access and building patients' trust in health care providers may improve the quality of dialysis and lead to better outcomes for patients with chronic kidney disease requiring hemodialysis. Copyright © 2014 National Kidney Foundation, Inc. Published by Elsevier Inc. All rights reserved.
Status MEDLINE

Institution Casey,Jordan R. Sydney School of Public Health, The University of Sydney, Sydney, NSW, Australia; Centre for Kidney Research, The Children's Hospital at Westmead, Westmead, Sydney, NSW, Australia. Hanson,Camilla S. Sydney School of Public Health, The University of Sydney, Sydney, NSW, Australia; Centre for Kidney Research, The Children's Hospital at Westmead, Westmead, Sydney, NSW, Australia.

Winkelmayer,Wolfgang C. Division of Nephrology, Stanford University, Palo Alto, CA. Craig,Jonathan C. Sydney School of Public Health, The University of Sydney, Sydney, NSW, Australia; Centre for Kidney Research, The Children's Hospital at Westmead, Westmead, Sydney, NSW, Australia. Palmer,Suetonia. University of Otago Christchurch, Christchurch, New Zealand. Strippoli,Giovanni F M. Sydney School of Public Health, The University of Sydney, Sydney, NSW, Australia; Medical Scientific Office, Diaverum, Lund, Sweden; Department of Emergency and Organ Transplantation, University of Bari, Bari, Italy. Tong,Allison. Sydney School of Public Health, The University of Sydney, Sydney, NSW, Australia; Centre for Kidney Research, The Children's Hospital at Westmead, Westmead, Sydney, NSW, Australia. Electronic address: allison.tong@sydney.edu.au. Date Created 20141203 Year of Publication 2014

2. Hemodialysis catheter outcomes pilot study: no dressing coverage with prescribed showering. Evans EC; Hain D; Kear TM; Dork LA; Schrauf C. Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association. 41(1):53- 64; 72; quiz 65, 2014 Jan-Feb. [Journal Article] UI: 24689265

This six-month prospective, multi-site study incorporated no dressing coverage over hemodialysis central venous catheter exit sites and compared the outcomes of two groups of patients receiving incenter hemodialysis: a shower group and a non-shower group. Outcomes included exit site infection rates, tunnel infection rates, and catheter-related bloodstream infection rates. The study enrolled 40 patients--31 patients in the shower group and nine patients in the non-shower group. The study was initially designed as a randomized controlled study, but after a month of enrolling patients, most patients insisted on being in the shower group. Results for both groups demonstrated infection rates that were not statistically different and were below levels reported in other studies. The qualitative satisfaction in ability to shower by patients in this study was an additional important finding. Status MEDLINE Authors Full Name Evans, Elizabeth C; Hain, Debra; Kear, Tamara M; Dork, Leslie A; Schrauf, Christine. Date Created 20140402 Year of Publication 2014

3. A systematic review of buttonhole cannulation practices and outcomes. [Review] Grudzinski A; Mendelssohn D; Pierratos A; Nesrallah G. Seminars in Dialysis. 26(4):465-75, 2013 Jul-Aug. [Journal Article. Review] UI: 23859189

Buttonhole (constant site) cannulation has emerged as an attractive technique for needling arteriovenous fistulae. However, the balance of benefits and harms associated with this intervention is unclear. We conducted a systematic review of studies reporting outcomes with buttonhole cannulation. The setting and population included adult patients receiving home or center hemodialysis. We searched MEDLINE, Embase (1980-June 2012), and CINAHL (1997- June 2012), for randomized and observational studies. We also searched conference proceedings (2009-2011). The interventions included: 1) buttonhole cannulation established by sharp needles, with or without a polycarbonate peg, 2) rope-ladder cannulation. Outcomes of interest included: Facility practices, systemic infection, local infection, access survival, access interventions, access-related

hospitalization, patient survival, pain, quality of life, and aneurysm formation. We identified 23 full-text articles and 4 abstracts; 3 were open-label trials, and the remainder observational studies of varying design and methodological quality. Studies were predominantly descriptive and lacked direct comparisons between buttonhole and rope-ladder cannulation. No qualitative differences in outcomes were noted among home and center hemodialysis patients using buttonhole cannulation. Rates of bacteremia were generally higher with buttonhole cannulation. Studies reporting access survival, hospitalization, quality of life, pain, and aneurysm formation had serious methodological limitations that limited our confidence in their estimates of effect. Among the various facility practices that were described, only the application of mupirocin cream was noted to be associated with reduced risk of infection. Limitations in included studies were short follow-up, crossover designs, lack of parallel control groups, and the use of patient-reported outcome measures that were not well validated. The main limitation of this review was a limited literature search. Buttonhole cannulation may be associated with an increased risk of infection. Larger, more definitive studies are needed to determine whether this technique is safe for broader use. Copyright © 2013 Wiley Periodicals, Inc. Status MEDLINE Authors Full Name Mendelssohn, David; Pierratos, Andreas; Nesrallah, Gihad.

Institution Grudzinski,Alexa. Division of Nephrology, Western University, London, Canada. Date Created 20130717 Year of Publication 2013

4. Optimizing renal replacement therapy in older adults: a framework for making individualized decisions. [Review] Tamura MK; Tan JC; O'Hare AM. Kidney International. 82(3):261-9, 2012 Aug. [Journal Article. Research Support, N.I.H., Extramural. Review] UI: 22089945

It is often difficult to synthesize information about the risks and benefits of recommended management strategies in older patients with end-stage renal disease since they may have more comorbidity and lower life expectancy than patients described in clinical trials or practice guidelines. In this review, we outline a framework for individualizing end-stage renal disease management decisions in older patients. The framework considers three factors: life expectancy, the risks and benefits of competing treatment strategies, and patient preferences. We illustrate the use of this framework by applying it to three key end-stage renal disease decisions in older patients with varying life expectancy: choice of dialysis modality, choice of vascular access for hemodialysis, and referral for kidney transplantation. In several instances, this approach might provide support for treatment decisions that directly contradict available practice guidelines, illustrating circumstances when strict application of guidelines may be inappropriate for certain patients. By combining quantitative estimates of benefits and harms with qualitative assessments of patient preferences, clinicians may be better able to tailor treatment recommendations to individual older patients, thereby improving the overall quality of end-stage renal disease care. Status MEDLINE Authors Full Name Tan, Jane C; O'Hare, Ann M.

Institution Tamura,Manjula Kurella. Division of Nephrology, Stanford University School of Medicine, Palo Alto, California 94304, USA. mktamura@stanford.edu Comments

Comment in: Kidney Int. 2012 Dec;82(12):1340-1; PMID: 23203026 Other ID Source: NLM. NIHMS376013 Source: NLM. PMC3396777 Date Created 20120713 Year of Publication 2012

5. Patient attitudes towards the arteriovenous fistula: a qualitative study on vascular access decision making. Xi W; Harwood L; Diamant MJ; Brown JB; Gallo K; Sontrop JM; MacNab JJ; Moist LM. Nephrology Dialysis Transplantation. 26(10):3302-8, 2011 Oct. [Journal Article. Research Support, Non-U.S. Gov't] UI: 21406543

BACKGROUND: The use of arteriovenous fistulas (AVFs) among hemodialysis (HD) patients has been consistently associated with lower rates of morbidity and mortality; however, up to 30% of eligible patients refuse the creation or cannulation of an AVF. We aimed to understand the attitudes, beliefs, preferences and values of patients who refused creation or use of an AVF. METHODS: With qualitative methodology, we conducted semi-structured interviews with 13 HD patients (Canada, 2009), who previously refused creation or use of an AVF. Three independent analysts reviewed interview transcripts. RESULTS: We discovered three main themes that impacted the decision to refuse a fistula: (i) poor previous personal or vicarious experiences with the fistula, including cannulation, bleeding, time commitment and appearance; (ii) knowledge transfer and informed decision making. Patients identified information from other patients to be as important as information from health care workers, that information on vascular access (VA) was presented but not understood and that timing of information was crucial with information overload at the start of dialysis and (iii) maintenance of status quo and outlook on life. Some patients stated they live day-to-day without being influenced by the mortality risks with a catheter. CONCLUSIONS: AVF refusal is multifactorial and depends on individual patients. Although nephrologists consider the fistula to be the optimal VA, patients do not think in the same terms of reducing infection rates but focus on the practical day-to-day use of their VA and its influence on their quality of life and future outlook. Status MEDLINE Authors Full Name Harwood, Lori; Diamant, Michael J; Brown, Judith Belle; Gallo, Kerri; Sontrop, Jessica M; MacNab, Jennifer J; Moist, Louise M. Institution Xi,Wang. Division of Nephrology, Department of Medicine, London Health Sciences Center and the University of Western Ontario, London, Canada. Date Created 20111017 Year of Publication 2011

6. Barriers to timely arteriovenous fistula creation: a study of providers and patients. Lopez-Vargas PA; Craig JC; Gallagher MP; Walker RG; Snelling PL; Pedagogos E; Gray NA; Divi MD; Gillies AH; Suranyi MG; Thein H; McDonald SP; Russell C; Polkinghorne KR. American Journal of Kidney Diseases. 57(6):873-82, 2011 Jun. [Comparative Study. Journal Article. Multicenter Study. Research Support, Non-U.S. Gov't] UI: 21411202

BACKGROUND: Current clinical practice guidelines recommend a native arteriovenous fistula (AVF) as the vascular access of first choice. Despite this, most patients in western countries start hemodialysis therapy using a catheter. Little is known regarding specific

physician and system characteristics that may be responsible for delays in permanent access creation. STUDY DESIGN: Multicenter cohort study using mixed methods; qualitative and quantitative analysis. SETTING & PARTICIPANTS: 9 nephrology centers in Australia and New Zealand, including 319 adult incident hemodialysis patients. PREDICTOR: Identification of barriers and enablers to AVF placement. OUTCOMES: Type of vascular access used at the start of hemodialysis therapy. MEASUREMENTS: Prospective data collection included data concerning predialysis education, interviews of center staff, referral times, and estimated glomerular filtration rate (eGFR) at AVF creation and dialysis therapy start. RESULTS: 319 patients started hemodialysis therapy during the 6-month period, 39% with an AVF and 59% with a catheter. Perceived barriers to access creation included lack of formal policies for patient referral, long wait times for surgical review and access placement, and lack of a patient database for management purposes. eGFR thresholds at referral for and creation of vascular accesses were considerably lower than appreciated (in both cases, median eGFR of 7 mL/min/1.73 m(2)), with median wait times for access creation of only 3.7 weeks. First assessment by a nephrologist less than 12 months before dialysis therapy start was an independent predictor of catheter use (OR, 8.71; $P < 0.001$). Characteristics of the best performing centers included the presence of a formalized predialysis pathway with a centralized patient database and low nephrologist and surgeon to patient ratios. LIMITATIONS: A limited number of patient-based barriers was assessed. Cross-sectional data only. CONCLUSIONS: A formalized predialysis pathway including patient education and eGFR thresholds for access placement is associated with improved permanent vascular access placement.Copyright © 2011 National Kidney Foundation, Inc. Published by Elsevier Inc. All rights reserved. Status MEDLINE Authors Full Name Craig, Jonathan C; Gallagher, Martin P; Walker, Rowan G; Snelling, Paul L; Pedagogos, Eugenia; Gray, Nicholas A; Divi, Murthy D; Gillies, Alastair H; Suranyi, Michael G; Thein, Hla; McDonald, Stephen P; Russell, Christine; Polkinghorne, Kevan R.

Institution Lopez-Vargas,Pamela A. Centre for Kidney Research, The Children's Hospital at Westmead, Sydney, Australia. Comments Comment in: Am J Kidney Dis. 2011 Jun;57(6):814-7; PMID: 21601127 Date Created 20110523 Year of Publication 2011

7. Exploring the impact of a decision support intervention on vascular access decisions in chronic hemodialysis patients: study protocol. Murray MA; Thomas A; Wald R; Marticorena R; Donnelly S; Jeffs L. BMC Nephrology. 12:7, 2011. [Journal Article. Research Support, Non-U.S. Gov't] UI: 21288366

BACKGROUND: In patients with Stage 5 Chronic Kidney Disease who require renal replacement therapy a major decision concerns modality choice. However, many patients defer the decision about modality choice or they have an urgent or emergent need of RRT, which results in them starting hemodialysis with a Central Venous Catheter. Thereafter, efforts to help patients make more timely decisions about access choices utilizing education and resource allocation strategies met with limited success resulting in a high prevalent CVC use in Canada. Providing decision support tailored to meet patients' decision making needs may improve this situation. The Registered Nurses Association of Ontario has developed a clinical practice guideline to guide decision support for adults living with Chronic Kidney Disease (Decision Support for Adults with Chronic Kidney Disease.) The purpose of this study is to determine the impact of

implementing selected recommendations this guideline on priority provincial targets for hemodialysis access in patients with Stage 5 CKD who currently use Central Venous Catheters for vascular access. METHODS/DESIGN: A non-experimental intervention study with repeated measures will be conducted at St. Michaels Hospital in Toronto, Canada. Decisional conflict about dialysis access choice will be measured using the validated SURE tool, an instrument used to identify decisional conflict. Thereafter a tailored decision support intervention will be implemented. Decisional conflict will be re-measured and compared with baseline scores. Patients and staff will be interviewed to gain an understanding of how useful this intervention was for them and whether it would be feasible to implement more widely. Quantitative data will be analyzed using descriptive and inferential statistics. Statistical significance of difference between means over time for aggregated SURE scores (pre/post) will be assessed using a paired t-test. Qualitative analysis with content coding and identification of themes will be conducted for the focus group and patient interview data. DISCUSSION: Coupling the SURE tool with a decision support system structured so that a positive test result triggers providers to help patients through the decision-making process and/or refer patients to appropriate resources could benefit patients and ensure they have the opportunity to make informed HD access choices. Status MEDLINE Authors Full Name Thomas, Alison; Wald, Ron; Marticorena, Rosa; Donnelly, Sandra; Jeffs, Lianne.

Institution Murray,Mary Ann. The Ottawa Hospital, Riverside Campus, 1967 Riverside Drive, Ottawa ON, K1BH 7W9, Canada. mmurray@toh.on.ca Other ID Source: NLM. PMC3051896 Date Created 20110310 Year of Publication 2011

8. The culture of vascular access cannulation among nurses in a chronic hemodialysis unit. Wilson B; Harwood L; Oudshoorn A; Thompson B. Cannt Journal. 20(3):35-42, 2010 Jul-Sep. [Journal Article. Research Support, Non-U.S. Gov't] UI: 21038828

The native arteriovenous fistula (AVF) is the vascular access of choice for patients on chronic hemodialysis (HD) because of its longevity and lower complication rate. Yet from 2001 to 2004 in Canada, there has been a notable increase in both incident and prevalent central venous catheter (CVC) use with a corresponding decrease in AVF use over the same time period (Moist, Trpeski, Na, & Lok, 2008). A similar trend has been found in other countries (Moist, Chang, Polkinghorne, & McDonald, 2007). There are a number of contributing factors to low AVF use in patients on chronic hemodialysis. While some of these factors may be patient-related, nursing interventions specific to cannulation may be a contributor. To date, little is known about HD nurses' attitudes and experiences regarding cannulation. The purpose of this study was to describe the culture and everyday practices of vascular access cannulation of the AVF from the perspective of the HD nurse. An ethnographic research design was employed, utilizing qualitative methods. Ten HD nurses were interviewed using a semi-structured interview tool, and a number of themes were generated from the interviews. One overarching theme of "perpetual novice" was evident, acknowledging the failure to transition from novice to expert cannulator despite working in HD for a number of years. Other common themes that emerged from the interviews were a) the lack of fistulas, b) the fistula as a "hard sell" to patients, c) the skill of cannulation, and d) the assembly- line approach to care. As a result of a number of factors, HD nurses were unable to acquire the skills

necessary to become an expert cannulator. Moreover, the decrease in opportunities to practise cannulation has resulted in wide variation in skill level among HD nurses. To improve cannulation skills and achieve successful cannulation of AV fistulas, HD nurses identified a number of educational strategies that should take place. They also identified the need for an improved documentation system in order to track cannulation-related problems. Results of this study may be helpful in understanding the culture of cannulation in a chronic HD unit and in directing future educational, supportive, and practice interventions for HD nurses. Status MEDLINE Authors Full Name Harwood, Lori; Oudshoorn, Abe; Thompson, Bonita.

Institution Wilson,Barbara. London Health Sciences Centre, Victoria Hospital, London, Ontario. barb.wilson@lhsc.on.ca Date Created 20101102 Year of Publication 2010

9. [Census 2004 of the Italian renal and dialysis units. Basilicata - Calabria - Puglia]. [Italian] Gesualdo L; Alloatti S; Cicchetti T; Iannuzziello F; Ktena M; Roselli D; Casino F; Marino C; Postorino M. Giornale Italiano di Nefrologia. 23(3):323-36, 2006 May-Jun. [English Abstract. Journal Article] UI: 16868912 UNLABELLED: The Italian Society of Nephrology (SIN) sponsored in 2004 a National Census of the Italian renal and dialysis units. This paper presents the main structural, technical, organizational features, as well as the human resources and the activities of three South-East regions of Italy: Basilicata (B), Calabria (C), and Puglia (P). EPIDEMIOLOGY: incidence of dialysis patients was 149 per million population (pmp) in B, 134 pmp in C and 172 pmp in P; prevalence of dialysis patients 729, 694 and 886 pmp, respectively; prevalence of transplanted patients 188 in B, 264 in C and 249 pmp in P; gross mortality rate of dialysis patients was 12.7% (B), 12.2% (C) and 10.8% (P). TYPE OF VASCULAR ACCESS IN PREVALENT DIALYSIS PATIENTS: arteriovenous fistula: 83.9% (B), 87.7% (C) and 86.5% (P); central venous catheter: 14.2% (B), 8.4% (C) and 11.2% (P); vascular graft 1.9% (B), 3.9% (C) and 2.3% (P). STRUCTURAL RESOURCES: nephrological beds 37, 34 and 88 pmp, respectively; dialysis stations 265, 209 and 207 pmp. PERSONNEL RESOURCES: renal physicians 45 (B), 67 (C) and 64(P) pmp; renal nurses 189, 190 and 207 pmp; each nephrologist cares for 16 (B), 10 (C) and 14 (P) dialysis patients, whereas each renal nurse takes care of 3.8 (B), 3.7 (C) and 4.3 (P) dialysis patients. ACTIVITY: hospitalizations 1378, 1834 and 3439 pmp, respectively; renal biopsies 40 (B), 64 (C) and 107 (P) pmp. The main goal of this project was to create a reference for benchmarking studies. Therefore, data from the Puglia region were compared to data from other regions with similar population size (such as Piemonte and Emilia-Romagna). Moreover, a Census may became a useful qualitative tool for renal registries: this report compares data from the Census with data collected by the dialysis and transplantation registry of the Puglia region. Generally speaking, prevalence for Basilicata and Calabria is close to the Italian one, whereas incidence is inferior; things are opposite in Puglia. Furthermore, compared to Basilicata, Calabria and Italy on average, the Puglia region shows a significant higher number of in-patient beds and a lower DRG weight. Compared to Piemonte, Emilia Romagna and Italy on average, all the three South-East regions do not show differences in number/pmp of dialysis centres. More physicians (nephrologists = 80%) are reported to be active in Puglia and Calabria, compared to Piemonte and Emilia Romagna. Nurses in Puglia look after a greater number of dialysis patients than in

Calabria and Basilicata. The number of renal biopsies/ pmp is similar to the Italian mean only in Puglia; it is inferior in the other two regions. These data highlight many differences among these three South-East regions, as well as among Piemonte, Emilia Romagna and Puglia. A relevant inequality in health care structures and resources has been found and discussed. Status MEDLINE Authors Full Name Alloatti, S; Cicchetti, T; Iannuzziello, F; Ktena, M; Roselli, D; Casino, F; Marino, C; Postorino, M.

Institution Gesualdo,L. S C di Nefrologia e Dialisi, Azienda Ospedaliero-Universitaria OO.RR. di Foggia- Italy. l.gesualdo@unifg.it Date Created 20060726 Year of Publication 2006

Embase

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1. FDA approves variety of medical devices. Geller J. Journal of Clinical Engineering. 40 (1) (pp 4-9), 2014. Date of Publication: 20 Dec 2015. AN: 2014616137

Institution (Geller) 12100 Wilshire Blvd, Los Angeles, CA 20025, United States Publisher Lippincott Williams and Wilkins

2. 29th Annual Meeting of the European Association of Cardiothoracic Anaesthesiologists, EACTA 2014 and 14th International Congress on Cardiovascular Anesthesia, ICCVA 2014. Applied Cardiopulmonary Pathophysiology. Conference: 29th Annual Meeting of the European Association of Cardiothoracic Anaesthesiologists, EACTA 2014 and 14th International Congress on Cardiovascular Anesthesia, ICCVA 2014 (29)Italy. Conference Start: 20140917 Conference End: 20140919 Sponsor: Abbott Vascular, abbvie, CSL Behring, Edwards Lifesciences, GE Healthcare, Philips Healthcare, MEDICA-Gruppe, Quartier ad fontes musica. Conference Publication: Rameshkumar B.S., Manners J. (146 pages). 1 (pp 137-138), 2014. Date of Publication: 2014. AN: 75007475 The proceedings contain 157 papers.

The special focus in this conference is on Cardiovascular Anesthesia. The topics include: Feasibility and accuracy of intra-operative assessment of systolic pulmonary artery pressure by transoesophageal echocardiography; prognostic value of pre- and post-operative RV systolic function in patients referred for cardiac surgery; thoracic surgery for infectious diseases; lung deflation with Arndt blocker during video-assisted thoracoscopy; comparison of the effects of sevoflurane and desflurane on microcirculation in non-cardiac surgery; hyperoxia reduces regional myocardial oxygenation distal to acute coronary stenosis in swine; mechanical circulatory support with Impella 5.0 assist device in severe cardiogenic shock; independent predictive factors of postoperative renal replacement therapy after adult cardiac surgery; inhalation agents for the treatment of pulmonary hypertension in patients undergoing cardiac surgery; specifying indications for chest radiographs after cardiac surgery increase their efficacy and reduce their number; organ hierarchy during low blood flow on-pump; effect of increasing age on the haemodynamic response to thoracic epidural

anaesthesia; acute permissive hypercapnia during one lung ventilation; comparison between dopamine and phenylephrine in maintaining cerebral oxygen saturation in thoracic surgery; implementation of a modified WHO checklist for the cardiac catherization laboratory - a complete audit cycle; adherence to ACC/AHA guidelines does not decrease the incidence of MI in post-PCI patients undergoing non-cardiac surgery; treatment of gram-positive cardiovascular infections with daptomycin or vancomycin; effect of anti-platelet drugs on platelet microparticles during on-pump cardiac surgery; systemic and pulmonary phenotypes in relation to postoperative hypoxaemia; in vitro endothelial cell barrier disruption after exposure to plasma from patients subjected to cardiopulmonary bypass; scavenging of volatile anaesthetics during long-term sedation of critical care patients; the effects of red blood cell transfusion during cardiac surgery; effects of acute plasma volume expanion on renal perfusion, filtration and oxygenation after cardiac surgery; central venous oxygen saturation as trigger for blood transfusion in cardiovascular surgery patients; a comparison of three strategies for levosimendan administration in cardiac surgery patients with severe myocardial dysfunction; re-sternotomy for bleeding following cardiac surgery; effects of remote ischaemic preconditioning on cognitive function and neurologic injury in cardiac surgery; current practice of anesthesia in patients undergoing lung transplantation in Europe; an overview of cases in a cardiac centre in the United Kingdom; vasoplegia after implantation of a non-pulsatile left ventricular assist device; cerebral oximetry monitoring during transcatheter aortic valve implantation (TAVI) procedure; in a FAST-TRACK protocol remifentanil is not superior to standard sufentanil regime; helium post-conditioning increases caveolin 1 and 3 protein levels in serum of rats; estimating plasma oncotic pressure and its relationship with early morbidity in postoperative cardiac surgery; prediction of fluid responsiveness in patients with atrial fibrillation; changing glucose control target and risk of surgical site infection in a South-East Asian population; antifibrinolytics are not indicated in the pre-bypass period for first time sternotomy in cardiac patients; analysis of transfusion requirements in cardiac surgery patients using a method of recursive partitioning; cold agglutinins and cardiac surgery; novel dynamic near-infrared spectroscopy parameter monitoring during on-pump cardiac surgery; effects of near-infrared spectroscopy on cognitive dysfunction for patients undergoing elective coronary surgery; cardiovascular instability following phenytoin administration in cardiac intensive care; procedural sedation with dexmedeto-midine for transfemoral aortic valve implantation; freedom SOLO stentless aortic valve prosthesis; pre-operative fasting and postoperative metabolic response after coronary artery bypass grafting; the effect of induced hypotension on motor neuron protection in experimental spinal cord ischaemic/reperfusion injury in rats; the role of ethnicity in post coronary artery bypass graft atrial fibrillation in an Asian population; lung transplantation in critically ill patients with cystic fibrosis; patient satisfaction in cardiac anaesthesia; levosimendan in non-cardiac surgery; gel lubrication reduces fluid leakage past the endobronchial cuff of double lumen tubes; protective one lung ventilation for pulmonary resections; pre-operative renal function stratification and early cardiac ICU adverse events in coronary artery disease; parameters of renal function after myocardial revascularization with the use of cardiopulmonary bypass; haemodialysis in ICU patients results in cerebral microembolism; evaluation of outcomes for renal transplant recipients who undergo cardiac surgery and use of a novel stethoscope in a cardiac intensive care.

3. Data on the acuseal graft for Hemodialysis: An interview with Marc Glickman, MD.

Glickman M. Vascular Disease Management. 11 (4) (pp E101-E102), 2014. Date of Publication: April 2014. AN: 2014225629 Publisher HMP Communications

4. Catheter-related bloodstream infections review. Abebe A., Tener M., Waller S., El Atrouni W. Hospital Medicine Clinics. 3 (1) (pp e32-e49), 2014. Date of Publication: January 2014. AN: 2014213087

This article reviews the definitions, epidemiology, pathogenesis, diagnosis, management, complications, implications, performance improvement, and clinical guidelines of catheter-related bloodstream infections. © 2014 Elsevier Inc.

Institution (Abebe) Department of Internal Medicine and Hospital Medicine, University of Kansas Medical Center, 3901 Rainbow Blvd, Kansas City, KS 66160, United States (Tener) Internal Medicine Residency Program, University of Kansas Medical Center, 3901 Rainbow Blvd, Kansas City, KS 66160, United States (Waller, El Atrouni) Department of Internal Medicine and Infectious Disease, University of Kansas Medical Center, 3901 Rainbow Blvd, Kansas City, KS 66160, United States Publisher W.B. Saunders

5. Haemodialysis vascular access practice patterns in North Pakistan. Bhatti A.M., Mansoor J., Ahsin S., Salim B., Humayun J., Anwar I., Mir M., Aslam M., Mallick T. Medical Forum Monthly. 24 (7) (pp 10-14), 2013. Date of Publication: July 2013. AN: 2013630004

Introduction: Mortality and morbidity rates in patients on haemodialysis vary among different countries widely due to variation in vascular access practices. Documented evidence of patterns and practices of various vascular access modalities in our population is scarce to allow for development of local guidelines or formulating steps to encourage adoption of international guidelines in Pakistani healthcare setup. Objective: To assess Vascular Access practices for haemodialysis patients in five dialysis facilities of Northern Pakistan Study Design: cross sectional study Place and Duration of Study: This study was carried out at five dialysis facilities in three cities of Northern Pakistan over a period of one year from March 2011 to March 2012. Materials and Methods: This cross sectional survey was completed by interviewing 536 end stage renal disease patients between 18 to 70 years of age over a period of one year. Duration of dialysis, types of access, current state and past history of vascular access were recorded and compared with International guidelines. Results: Commonest 'current vascular access' was found to be AV fistula in 317 out of 536 patients (almost 60%) and the most common mode of 'first Vascular Access' (i.e. vascular access first used for haemodialysis) was catheter (83%). Amongst patients who had dialysis during last eight months, 76.27% were still being dialysed via percutaneous catheters while this figure is less than 34% in Europe. Conclusion: Although the initial mode of dialysis in most cases is a line yet, majority of patients are dialyzed through native fistula. Need for a pre-emptive fistula is required to have superior longevity and fewer complications in haemodialysis patients.

Institution (Bhatti, Humayun, Anwar) CMH Rawalpindi, Pakistan (Mansoor) CMH

Peshawar, Pakistan (Ahsin) Department of Physiology, Foundation University Medical College, Pakistan (Salim) PIMS Islamabad, Pakistan (Mir, Aslam, Mallick) Foundation University Medical College, Pakistan Publisher Medical Forum (Monthly) (Gujjar Singh, Lahore 5460, Pakistan)

6. Interventional nephrology: A big opportunity for a big problem. Vachharajani T.J. Open Urology and Nephrology Journal. 5 (SPEC.ISS.1) (pp 3), 2012. Date of Publication: 2012. AN: 2013581449

Institution (Vachharajani) Nephrology Section, W. G. (Bill) Hefner Veterans Affairs Medical Center, Salisbury, NC-28144, United States Publisher Bentham Science Publishers B.V. (P.O. Box 294, Bussum 1400 AG, Netherlands)

7. What lies beneath: Posterior ST elevation myocardial infarction with underlying right ventricular- paced rhythm. Browning A.C., Schaefer S. Experimental and Clinical Cardiology. 18 (1) (pp e55-e56), 2013. Date of Publication: Spring 2013. AN: 2013339503

A 66-year-old man with a history of coronary artery disease, stage V chronic kidney disease, peripheral arterial disease and a dual-chamber pacemaker experienced persistent chest and shoulder discomfort following his daily hemodialysis treatment. Treatment with clopidogrel had been discontinued three days previously due to impending vascular surgery. Electrocardiography revealed a right ventricular-paced rhythm with ST abnormalities indicative of posterior ST elevation myocardial infarction. The patient underwent urgent cardiac catheterization and required percutaneous coronary intervention for an acutely occluded coronary artery. The present case report emphasizes the importance of careful and timely review of the electrocardiogram of any patient with a ventricular-paced rhythm who experiences signs and symptoms consistent with acute coronary syndrome. Certain characteristic electrocardiographic abnormalities have been demonstrated to predict acute myocardial infarction in such patients. ©2013 Pulsus Group Inc. All rights reserved. Institution (Browning, Schaefer) Division of Cardiovascular Medicine, University of California, Davis, Davis, CA, United States Publisher Pulsus Group Inc. (2902 South Sheridan Way, Oakville ONT L6J 7L6, Canada)

8. Comparative analysis of vascular access for haemodialysis in end-stage renal disease in a developing and developed country. Arodiwe E.B., Eze J.C. Internet Journal of Third World Medicine. 10 (1) , 2011. Date of Publication: 2011. AN: 2013151681

Background: End Stage Renal disease (ESRD) is an important and growing medical problem all over the world especially in developing countries. Securing adequate vascular access is an essential part of managing affected patients. Objectives: To compare vascular access routes for haemodialysis in a developed and developing

country setting.Method: Case notes were studied for information on age, gender, vascular access routes at University of Nigeria teaching hospital (UNTH) from January to July 2000. Operation lists and case notes used at Texas Heart Institute (THI) from October 2005 to March 2006 were reviewed to provide the above information. The findings were compared. Result: One hundred and fifty nine and Ninety four patients at THI and UNTH respectively were studied. There was similar gender pattern among patients seen at both institutions. The mean age in years of patients with ESRD requiring haemodialysis was lower at UNTH (44.6+/-17.1 as against 56.2+/-14.8 in THI), p<0.001. Direct femoral vein cannulation was the main vascular access route in UNTH (93.6%), whereas left hand arteriovenous graft (AVG) was the commonest route at THI (34.6%). Conclusion: We conclude that the prevalent vascular routes differ in these two centers with THI having a well established renal replacement protocol. The important challenges at UNTH include inadequate manpower, general poverty of the patients, lack of vascular access creation materials and unavailability of organized health policy for patients with ESRD in Nigeria. These problems are common in most developing countries. © Internet Scientific Publications, LLC., 1996 - 2013.

Institution (Arodiwe, Eze) Department of Medicine, Renal Unit, University of Nigeria Teaching Hospital, Ituku-Ozalla, Enugu, Nigeria Publisher Internet Scientific Publications LLC (23 Rippling Creek Drive, Sugar Land TX 77479, United States)

9. How to deal with dialysis catheters in the ICU setting. Mrozek N., Lautrette A., Timsit J.-F., Souweine B. Annals of Intensive Care. 2 (1) , 2012. Date of Publication: 2012. AN: 2012733906 Acute kidney insufficiency (AKI) occurs frequently in intensive care units (ICU). In the management of vascular access for renal replacement therapy (RRT), several factors need to be taken into consideration to achieve an optimal RRT dose and to limit complications. In the medium and long term, some individuals may become chronic dialysis patients and so preserving the vascular network is of major importance. Few studies have focused on the use of dialysis catheters (DC) in ICUs, and clinical practice is driven by the knowledge and management of long- term dialysis catheter in chronic dialysis patients and of central venous catheter in ICU patients. This review describes the appropriate use and management of DCs required to obtain an accurate RRT dose and to reduce mechanical and infectious complications in the ICU setting. To deliver the best RRT dose, the length and diameter of the catheter need to be sufficient. In patients on intermittent hemodialysis, the right internal jugular insertion is associated with a higher delivered dialysis dose if the prescribed extracorporeal blood flow is higher than 200 ml/min. To prevent DC colonization, the physician has to be vigilant for the jugular position when BMI < 24 and the femoral position when BMI > 28. Subclavian sites should be excluded. Ultrasound guidance should be used especially in jugular sites. Antibiotic-impregnated dialysis catheters and antibiotic locks are not recommended in routine practice. The efficacy of ethanol and citrate locks has yet to be demonstrated. Hygiene procedures must be respected during DC insertion and manipulation. © 2012 Mrozek et al.

Institution (Mrozek, Lautrette, Souweine) Medical Intensive Care Unit, Auvergne University Gabriel Montpied Hospital, Clermont Ferrand 63000, France (Mrozek, Lautrette, Souweine) UMR CNRS 6023, Laboratoire Microorganismes: Genome et

Environnement, Clermont Universite, Auvergne University, Gabriel Montpied Hospital, Clermont Ferrand 63000, France (Timsit) Medical Polyvalent Intensive Care Unit, University Joseph Fourier, Albert Michallon Hospital, BP 217, Grenoble Cedex 9 38043, France (Timsit) University Joseph Fourier, EA U823, Albert Bonniot Institute, La Tronche Cedex 38706, France Publisher Springer Verlag (Tiergartenstrasse 17, Heidelberg D-69121, Germany)

10. Economic Burden of Incident Unplanned Starts on Peritoneal Dialysis in a High Specialty Health Care Facility in Mexico City. Hdez Ordonez S.O., Walton S.M., Ramos A., Valle L., Rivera A.S., Liu F.X. Value in Health Regional Issues. 1 (2) (pp 184-189), 2012. Date of Publication: December 2012. AN: 2012729582

Objectives: Few studies have examined hospitalization costs for unplanned initiation of peritoneal dialysis (PD). We used data from a health care facility in Mexico to examine first hospitalization costs associated with the unplanned initiation of PD. Methods: Descriptive analyses focusing on initial hospitalization costs during the unplanned initiation of PD were conducted. In addition, multivariate regression models examined the association of costs with requiring urgent hemodialysis (HD) at the time of starting PD, and the association of driving distance with requiring urgent HD. Results: Of 195 patients hospitalized in 2010 for PD catheter placement, 51 patients met criteria for unplanned PD initiation and 25 of them required urgent HD prior to PD initiation. Ninety-two percent of the patients received 90% or greater government subsidy of hospital costs. Average inpatient costs for the first hospitalization related to the unplanned initiation of PD were 64,174 Mexican Pesos (MXN) (US $4,657). Costs were 78,683 MXN ($5,710) per patient for those requiring urgent HD and 50,225 MXN ($3,645) for those who did not, a difference ($P<0.05$) of roughly 28,000 MXN ($2,032), and regression results were similar. In addition, long driving distance to the institution was significantly associated with requiring urgent HD. Conclusions: Our findings highlight potential cost savings to payers for developing better strategies to manage PD starts in Mexico and should help inform policy regarding oversight and coverage of low-income patients at risk of dialysis. © 2012 International Society for Pharmacoeconomics and Outcomes Research (ISPOR).

Institution (Hdez Ordonez) Nephrology Department, Instituto Nacional de Cardiologia Ignacio Chavez, Mexico City, Mexico (Walton) Department of Pharmacy Administration, University of Illinois at Chicago, Chicago, IL, United States (Ramos, Valle) Baxter Mexico, Chapultepec Morales, Mexico DF, Mexico (Rivera) Baxter Latin America, Baxter Colombia, Bogota, Colombia (Liu) Global Health Economics and Outcomes Research, Baxter Healthcare Corporation, Deerfield, IL, United States Publisher Elsevier Inc. (360 Park Avenue South, New York NY 10010, United States)

11. Importance of access centers and their certification. <Bedeutung von shunt-zentren und deren zertifizierung.> Mickley V. Gefasschirurgie. 17 (5) (pp 323-326), 2012. Date of Publication: September 2012. AN: 2012656000 The incidence and prevalence of end-stage renal disease in Germany is rising steadily. Due to the demographic

development more and more elderly, diabetic and atherosclerotic patients need renal replacement therapy and most receive hemodialysis. Creating and maintaining a functioning arteriovenous access in every patient has become an obvious real challenge. As a consequence the relative and absolute numbers of dialysis patients with a catheter have dramatically increased in recent years. Establishing certified access centers could help to deal with the rapidly growing multimorbid patient population, to provide optimal primary access and adequate around-the-clock treatment of possible complications. © Springer-Verlag 2012.

Institution (Mickley) Fachbereich Gefaschirurgie, Am Klinikum Mittelbaden, Kreiskrankenhaus Rastatt, Engelstr. 39, 76437 Rastatt, Germany Publisher Springer Verlag (Tiergartenstrasse 17, Heidelberg D-69121, Germany)

12. Emergent Complications and Management of Children With End-Stage Renal Disease. Phillips J., Gaskins J., Lawrence L. Clinical Pediatric Emergency Medicine. 13 (2) (pp 99-105), 2012. Date of Publication: June 2012. AN: 2012500793

End-stage renal disease is the result of complete or near-complete renal failure. Once renal function is lost, patients have difficulty eliminating excess fluids and waste from the body. Most pediatric patients rely on peritoneal dialysis for renal replacement, although a small population will undergo hemodialysis. A common complication of renal failure is electrolyte abnormalities, especially hyperkalemia. These patients are also at risk for catheter site infections as well as intraperitoneal infections. This article will review common disease complications and emergency care needs for children with end-stage renal disease. © 2012 Elsevier Inc.

Institution (Phillips, Gaskins, Lawrence) Vanderbilt University Medical Center, Division of Pediatric Emergency Medicine, Nashville, TN, United States Publisher W.B. Saunders Ltd (32 Jamestown Road, London NW1 7BY, United Kingdom)

13. Challenges of hemodialysis in India. Bhowmik D., Tiwari S.C. Journal International Medical Sciences Academy. 25 (2) (pp 99-100), 2012. Date of Publication: April-June 2012. AN: 2012451633

Hemodialysis in India has improved by leaps over the last two decades. However there is a long way to go. There is still late diagnosis, late referral of kidney patients and issues remain of accessibility to hemodialysis centres along with finances. Intensive public, patient and primary care physician education, government backing and induction of more trained personnel will make hemodialysis a successful RRT modality in India.
Institution (Bhowmik) Dept. of Nephrology AIIMS, Anasari Nagar, New Delhi, India (Tiwari) Nephrology and Renal Transplant Medicine, Fortis Institute of Renal Science and Transplantation, New Delhi, India Publisher International Medical Sciences Academy (Ansari Nagar, Ring Road, New Delhi 110029, India)

14. Renal replacement therapy in ICU. Deepa C., Muralidhar K. Journal of Anaesthesiology Clinical Pharmacology. 28 (3) (pp 386-396), 2012. Date of Publication: July-September 2012. AN: 2012437442

Diagnosing and managing critically ill patients with renal dysfunction is a part of the daily routine of an intensivist. Acute kidney insufficiency substantially contributes to the morbidity and mortality of critically ill patients. Renal replacement therapy (RRT) not only does play a significant role in the treatment of patients with renal failure, acute as well as chronic, but also has spread its domains to the treatment of many other disease conditions such as myaesthenia gravis, septic shock and acute on chronic liver failure. This article briefly outlines the role of renal replacement therapy in ICU.

Institution (Deepa, Muralidhar) Narayana Hrudayalaya, Bangalore,Karnataka, India Publisher Medknow Publications and Media Pvt. Ltd (B9, Kanara Business Centre, off Link Road, Ghatkopar (E), Mumbai 400 075, India)

15. HBA1C is independent prognostic factor for elderly ESRD patients. Kwon S.H., Jeon J.S., Noh H., Han D.C. Kidney Research and Clinical Practice. Conference: 16th International Congress on Nutrition and Metabolism in Renal Disease 2012 Honolulu, HI United States. Conference Start: 20120626 Conference End: 20120630. Conference Publication: (var.pagings). 31 (2) (pp A47-A48), 2012. Date of Publication: June 2012. AN: 70814833

The eldery constituted the fast growing segment of the end-stage renal disease (ESRD) population. However, the information about the elderly patients on hemodilaysis therapy is limited. We investigated outcomes and the prognostic factors for elderly patients who initiated hemodialysis. We reviewed medical recodes and conducted survival analysis in elderly patients over than 75 years when they had started hemodialysis in single center between 1988 and 2010. We analyzed the survival time of elderly hemodialysis patients with Korean national health insurance data system. Sixty hundred and sixty eight patients initated hemodialysis from 1988 and sixty five patients among them were over than 75 years. Their median survival from initiation of hemodialysis was 29.02 (13.31-49.51) months. The survival in patients whose HbA1c level was higher than 7.0% was lower than in their counterpart (32.85 Vs 13.31 months; P=0.0014).The patients with AVBG and AVF showed much better survival compared to catheter (36.75, 32.46 Vs 3.26 months; P=0.0016). The patients over than 80 years were 43% and their survival was much lower than the patients younger than 80 years (16.00 Vs 36.75 months ; P=0.0107). Cox regression analysis showed the HbA1C 47.0% is independent prognostic factor. (HR=4.66 (1.79- 12.16), p=0.002). In conclusion, Diabeus mellitus per se was not a risk factor for mortality in this group. However untrolled diabetes mellitus is independent prognostic factor for elderly ESRD patients.

Institution (Kwon, Jeon, Noh, Han) Soonchunhynag University Hospital, Seoul, South Korea Publisher Elsevier

16. Czech Society of Cardiology guidelines for the diagnosis and treatment of chronic heart failure 2011. Spmar J., Vitovec J., Hradec J., Malek I., Meluzin J., Spmarova L., Hoskova L., Hegarova M., Ludka O., Tahorsky M. Cor et Vasa. 54 (2) (pp E113-E134), 2012. Date of Publication: March-April 2012. AN: 2012336285

Guidelines of Czech Society of Cardiology are released in accordance with ESC guidelines for the diagnosis and treatment of acute and chronic heart failure. Guidelines summarise and evaluate all currently available knowledge about a particular issue, and whenever it is possible they are based on EBM-Evidence Based Medicine. Two classifications of level of evidence and the strength of recommendation are used as seen below. © 2012 The Czech Society of Cardiology. Published by Elsevier Urban & Partner Sp.z.o.o. All rights reserved.

Institution (Spmar, Ludka) Department of Internal Medicine - Cardiology, Masaryk University, University Hospital Brno, Jihlavska 20, Brno, Czech Republic (Vitovec, Meluzin, Spmarova) 1st Department of Internal Medicine - Cardioangiology, Masaryk University, St. Anne's University Hospital Brno, Pekarska 53, Brno, Czech Republic (Hradec) 3rd Department of Internal Medicine, Charles University, General University Hospital in Prague, U Nemocnice 2, Prague 2, Czech Republic (Malek, Hoskova, Hegarova) Department of Cardiology, Institute of Clinical and Experimental Medicine, Videnska 1958/9, Prague 4, Czech Republic (Tahorsky) 1st. Department of Internal Medicine - Cardiology, Faculty of Medicine, Palacky University and University Hospital, I. P. Pavlova 6, Olomouc, Czech Republic Publisher Elsevier Science B.V. (P.O. Box 1527, Amsterdam 1000 BM, Netherlands)

17. Interventional nephrology: A big opportunity for a big problem. Vachharajani T.J. Open Urology and Nephrology Journal. 5 (1) (pp 3), 2012. Date of Publication: 2012. AN: 2012325210

Institution (Vachharajani) Nephrology Section, W. G. (Bill) Hefner Veterans Affairs Medical Center, Salisbury, NC-28144, United States Publisher Bentham Science Publishers B.V. (P.O. Box 294, Bussum 1400 AG, Netherlands)

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Medline, retningslinjer

1. Indications for vascular grafts as hemodialysis access: consensus from experience in Italy. Tazza L; Galli F; Mandolfo S; Forneris G; Di Dio M; Palumbo R; Gallieni M; Bonforte G; Carnabuci A; Cavatorta F; Aloisi M; Carbonari L; Study Investigators PP1 SIN; Study Group on Vascular Access of the Italian Society of Nephrology. Journal of Vascular Access. 13(3):279-85, 2012 Jul-Sep. [Journal Article. Practice Guideline] UI: 22307468

INTRODUCTION: In Italy, the use of arteriovenous grafts (AVG) is limited (1-5 %) due to different approaches to vascular access (VA) management as compared to other countries, where guidelines (which may not apply to the Italian setting) have been produced. Therefore, the Study Group (GdS) on VA of the Italian Society of Nephrology produced this position paper, providing a list of 8 recommendations built upon current guidelines. METHODS: The most controversial and innovative issues of existing guidelines have been summed up in 12 different statements. We selected 60 Italian dialysis graft experts, nephrologists and vascular surgeons (PP1SIN Study Investigators). They were asked to express their agreement/disagreement on each issue, thus creating a new method to share and exchange information. RESULTS: Most of them agreed (consensus > 90%) on specific criteria set to choose AVG over native AVF (nAVF) and tunnelled venous catheter (tVC) and on the necessary conditions to implant them. They did not fully agree on the use of AVG in obese patients, in patients at risk of developing ischemia, on the priority of AVG as an alternative to brachial-basilic fistula with vein transposition, and in case of a poorly organized setting regarding graft maintenance. Keeping in mind that the nAVF should be preferred whenever is feasible, AVGs are indicated when superficial veins are unavailable or to repair a nAVF (bridge graft). An AVG is an alternative to tVC if the expected patient survival is long enough to guarantee its clinical benefits. Status MEDLINE

Authors Full Name Galli, Franco; Mandolfo, Salvatore; Forneris, Giacomo; Di Dio, Michele; Palumbo, Roberto; Gallieni, Maurizio; Bonforte, Giuseppe; Carnabuci, Antonio; Cavatorta, Fosco; Aloisi, Mauro; Carbonari, Luciano; Study Investigators PP1 SIN; Study Group on Vascular Access of the Italian Society of Nephrology. Institution Tazza,Luigi. Catholic University, Rome, Italy. luigi.tazza@gmail.com Date Created 20121001 Year of Publication 2012

2. Appendix to dialysis centre guidelines: recommendations for the relationship

between outpatient haemodialysis centres and reference hospitals. Opinions from the Outpatient Dialysis Group. Grupo de Trabajo de Hemodialisis Extrahospitalaria. Berdud I; Arenas MD; Bernat A; Ramos R; Blanco A; Grupo de Trabajo de Hemodialisis Extrahospitalaria (Outpatient Haemodialysis Group). Nefrologia. 31(6):664-9, 2011. [Consensus Development Conference. Journal Article. Practice Guideline] UI: 22130281

INTRODUCTION: The different clinical guidelines backed by the Spanish Society of Nephrology (SEN) attempt to homogenise the monitoring of renal patients. However, this effort to homogenise treatment has been obstructed in the case of renal replacement therapy patients on haemodialysis due to, among other reasons, the existence of several different dialysis providers, with private centres located in many cities, each with their own reference hospitals and different criteria for treatment based on the existing outsourcing services agreements with the public health service, which also differ between regions. A good relationship between a private dialysis centre and its reference hospital would lead to equal treatment for all dialysis patients, at least at that particular town. The SEN, through the efforts of the Grupo de Trabajo de Hemodialisis Extrahospitalaria (Outpatient Haemodialysis Group), has prioritised a close relationship and good communication between reference hospitals and dialysis centres in order to guarantee proper continuity of the health care given to these patients. STRATEGIES FOR IMPROVEMENT: Conditions for referring patients from one centre to another. A patient that starts a haemodialysis programme should be referred from a reference hospital with a definitive vascular access for optimising treatment, with a full report updated within 24-48 hours before the transferral, including essential information for providing proper nephrological treatment: primary pathology, recent viral serology (including hepatitis B and C virus [HBV and HCV] and human immunodeficiency virus [HIV]), parameters for anaemia and calcium-phosphorus metabolism, and ions, date of the first session of dialysis, and the number and dates of blood transfusions received. Furthermore, patients referred from the dialysis centre to the hospital, whether for programmed visits or emergency hospitalisation, should be accompanied by an updated report indicating the primary diagnoses, recent events, viral serology and laboratory analyses, updated haemodialysis and treatment regimens used, and the reason for transferral to the hospital. A single, digital clinical history that is accessible by both institutions would facilitate this situation, although this option is not completely available to all centres and hospitals. There are also legal issues to resolve in this aspect. Continued care for dialysis patients. Good communication between dialysis centres and hospitals is fundamental for achieving a proper level of care for dialysis patients, and not only with the nephrology department. The interconsultations of dialysis patients at each private centre, as well as the requests for diagnostic tests, should be able to be requested by the centre directly. The results and reports from these interconsultations should also be sent to the centre. It would also be best if the reference hospitals and their private dialysis centres shared common treatment protocols. These protocols should include basic aspects of the treatment of renal patients (anaemia, mineral metabolism, vascular accesses including catheter infections, etc., and laboratory tests), transplant protocols, complementary tests, and other components specific to each area. Not only would this generalise and unify the approach taken with dialysis patients regardless of where they are treated, it would also facilitate access to data on all patients regarding clinical trials and research studies. Access to medication. Dialysis patients require medications that are only given in the hospital setting, which is normally

provided by the reference hospital, as per the agreement between institutions. It would also be recommendable that any other medications not included in the agreement (antibiotics, urokinase, nutritional supplements, etc.) be dispensed in a similar manner. Access to kidney transplant. The management of the transplant waiting list, once a patient starts renal replacement therapy, should be controlled from the dialysis centre, as in any other procedure. As such, the nephrologists from each centre should be familiar with the existing protocols and new developments in this context, and should participate in meetings with nephrology and urology departments in each hospital. The transplant protocol at each town/region should be followed for all patients, whether dialysis is undergone in a hospital or private centre. Characteristics of the work at dialysis centres. The doctor attending patients at each dialysis centre must be a specialist in nephrology. This complicated issue must be a requirement for agreements within the regional health system in order to guarantee a proper and equitable treatment of patients that receive dialysis in private centres. Only in the case of an absence of a nephrologist should a general practitioner be used, and this doctor must have adequate training in haemodialysis. This training should also be standardised. Over 75% of nephrologists that work at these centres are alone during the workday, and 40% never see another colleague during the whole shift. The administrators of these centres should seek out protocols that provide professional contact, both with the hospital staff and nephrologists from other centres, which would facilitate an exchange of ideas. Training. The nephrologists at each centre have the right and the obligation to perform research and to continuously expand their training, so as to develop and improve health care provision. Since the majority of patients in haemodialysis programmes are treated in outpatient centres that depend on reference hospitals, we might suggest a minimal rotation of nephrology residents in private outpatient dialysis centres, once accreditation has been given for providing this training. Status MEDLINE Authors Full Name Arenas, M D; Bernat, A; Ramos, R; Blanco, A; Grupo de Trabajo de Hemodialisis Extrahospitalaria (Outpatient Haemodialysis Group). Institution Berdud,I. FMC Service Andalucia-Cordoba, Avda. Conde de Vallellano 19, Cordoba, Spain. iberdudg@senefro.org

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Embase, retningslinjer

Retningslinjer EMBASE

1. Catheter-related bloodstream infections review. Abebe A., Tener M., Waller S., El Atrouni W. Hospital Medicine Clinics. 3 (1) (pp e32-e49), 2014. Date of Publication: January 2014. AN: 2014213087

This article reviews the definitions, epidemiology, pathogenesis, diagnosis, management, complications, implications, performance improvement, and clinical guidelines of catheter-related bloodstream infections. © 2014 Elsevier Inc.

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Department of Internal Medicine and Infectious Disease, University of Kansas Medical Center, 3901 Rainbow Blvd, Kansas City, KS 66160, United States Publisher W.B. Saunders

2. Pets are 'risky business' for patients undergoing continuous ambulatory peritoneal dialysis. Al-Fifi Y.S.Y., Sathianathan C., Murray B.-L., Alfa M.J. Canadian Journal of Infectious Diseases and Medical Microbiology. 24 (3) (pp e96-e98), 2013. Date of Publication: Autumn 2013. AN: 2013740067

The authors report the first case in Manitoba of a patient undergoing continuous ambulatory peritoneal dialysis who experienced three successive infections with Pasteurella multocida and Capnocytophaga species over an eight-month period. These zoonotic infections were believed to originate from contact with the patient's household pets. To prevent such infections, the authors recommend the development and implementation of hygiene guidelines outlining the risks associated with owning domestic pets for continuous ambulatory peritoneal dialysis patients. ©2013 Pulsus Group Inc. All rights reserved.

Institution (Al-Fifi) Department of Medicine, University of Manitoba, Winnipeg, MB, Canada (Sathianathan) Department of Nephrology, St Boniface Hospital, Winnipeg, MB, Canada (Murray, Alfa) Diagnostic Services of Manitoba, St Boniface General Hospital, 409 Tache Avenue, Winnipeg, MB R2H 2A6, Canada Publisher Pulsus Group Inc. (2902 South Sheridan Way, Oakville ONT L6J 7L6, Canada)

3. Haemodialysis vascular access practice patterns in North Pakistan. Bhatti A.M., Mansoor J., Ahsin S., Salim B., Humayun J., Anwar I., Mir M., Aslam M., Mallick T. Medical Forum Monthly. 24 (7) (pp 10-14), 2013. Date of Publication: July 2013. AN: 2013630004

Introduction: Mortality and morbidity rates in patients on haemodialysis vary among different countries widely due to variation in vascular access practices. Documented evidence of patterns and practices of various vascular access modalities in our population is scarce to allow for development of local guidelines or formulating steps to encourage adoption of international guidelines in Pakistani healthcare setup. Objective: To assess Vascular Access practices for haemodialysis patients in five dialysis facilities of Northern Pakistan Study Design: cross sectional study Place and Duration of Study: This study was carried out at five dialysis facilities in three cities of Northern Pakistan over a period of one year from March 2011 to March 2012. Materials and Methods: This cross sectional survey was completed by interviewing 536 end stage renal disease patients between 18 to 70 years of age over a period of one year. Duration of dialysis, types of access, current state and past history of vascular access were recorded and compared with International guidelines. Results: Commonest 'current vascular access' was found to be AV fistula in 317 out of 536 patients (almost 60%) and the most common mode of 'first Vascular Access' (i.e. vascular access first used for haemodialysis) was catheter (83%). Amongst patients who had dialysis during last eight

months, 76.27% were still being dialysed via percutaneous catheters while this figure is less than 34% in Europe. Conclusion: Although the initial mode of dialysis in most cases is a line yet, majority of patients are dialyzed through native fistula. Need for a pre-emptive fistula is required to have superior longevity and fewer complications in haemodialysis patients.

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4. Vascular access and infection prevention and control: A national survey of routine practices in Irish haemodialysis units. McCann M., Clarke M., Mellotte G., Plant L., Fitzpatrick F. Clinical Kidney Journal. 6 (2) (pp 176-182), 2013. Date of Publication: April 2013. AN: 2013213293

Background National and international guidelines recommend the use of effective vascular access (VA) and infection prevention and control practices within the haemodialysis environment. Establishing an arterio-venous fistula (AVF) and preventing central venous catheter (CVC)- related infections are ongoing challenges for all dialysis settings. We surveyed VA and routine infection prevention and control practices in dialysis units, to provide national data on these practices in Ireland. MethodsA descriptive survey was emailed to nurse managers at all adult (n = 19) and children (n = 1) outpatient haemodialysis units in the Republic of Ireland. Data collected included AVF formation, CVC insertion and maintenance practices, VA use and surveillance of infection and screening protocols. Nineteen of the 20 units responded to the survey. ResultsThe AVF prevalence was 49% for 1370 patients in 17 units who provided these data [mean prevalence per unit: 45.7% (SD 16.2)]; the CVC mean prevalence per unit was 52.5% (SD 16.0). Fourteen dialysis units experienced inadequate access to vascular surgical procedures either due to a lack of dedicated theatre time or hospital beds. Six units administered intravenous prophylactic antimicrobials prior to CVC insertion with only two units using a CVC insertion checklist at the time of catheter insertion. Conclusion In general, dialysis units in Ireland show a strong adherence to national guidelines. Compared with the 12 countries participating in the Dialysis Outcomes Practice Patterns Study (DOPPS 4), in 2010, AVF prevalence in Irish dialysis units is the second lowest. Recommendations include establishing an AVF national prevalence target rate, discontinuing the administration of intravenous prophylactic antimicrobials prior to CVC insertion and promoting the use of CVC insertion checklists. © 2013 The Author.

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Hospital, Health Protection Surveillance Centre, Dublin, Ireland Publisher Oxford University Press (Great Clarendon Street, Oxford OX2 6DP, United Kingdom)

5. Care of the renal patient in radiology. Schwaner S.L., McGee III W.L. Journal of Radiology Nursing. 31 (4) (pp 120-129), 2012. Date of Publication: December 2012. AN: 2012712675

The incidence and prevalence of both renal disease and subsequent end-stage renal failure have increased dramatically in the past several years. It is estimated that 11.5% of adults (23 million) were diagnosed with chronic kidney disease as of 2004. Statistics indicate that in 2007 there were 527,284 people undergoing renal replacement therapy in the United States, with 111,000 of them starting therapy that year. It is estimated that this number could as much as double by 2020. The implications of this are that more patients than ever coming to the radiology department will be suffering from renal disease. Caring for these patients is a continuum of care. The purpose of this article is to prepare nurses to care for these patients in both the early and late stages of renal disease and most importantly, to treat them without negatively impacting their renal disease. © 2012 by the Association for Radiologic & Imaging Nursing.

Institution (Schwaner, McGee III) University of Virginia, Department of Radiology, Division of Interventional Radiology, 1215 Lee Street, Box 800377, Charlottesville, VA 22908-0037, United States Publisher Elsevier Inc. (360 Park Avenue South, New York NY 10010, United States)

6. Outpatient Parenteral Antimicrobial Therapy. Bowling J.E., Lewis J.S., Owens A.D. Hospital Medicine Clinics. 2 (1) (pp e45-e56), 2013. Date of Publication: January 2013. AN: 2012715432

Outpatient parenteral antimicrobial therapy (OPAT) began in the 1970s in the United States. It is estimated that 1 in 1000 Americans receives OPAT each year. OPAT should only be considered in select patients. There are minimal data on using OPAT in patients with substance abuse. A patient's home setting should be assessed before discharge. Consider obtaining written consent from the patient or caregiver before discharging on OPAT. Communication is a key component for an OPAT team. Only certain antimicrobials are candidates for continuous infusion at home. Tracking outcomes with OPAT is important to validate safety and efficacy of care provided. © 2013 Elsevier Inc.

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Health Science Center, 7703 Floyd Curl Drive, MSC 7982, San Antonio, TX 78229, United States Publisher W.B. Saunders (Independence Square West, Philadelphia PA 19106-3399, United States)

7. Vascular access related infections among hemodialysis patients in tritiary care centre, Tamilnadu. Lakshmanan A., Madhavan R., Padmanaaban International Journal of Pharma and Bio Sciences. 3 (3) (pp B7-B15), 2012. Date of Publication: July/September 2012. AN: 2012617993

Background: Vascular access related infections (VARI) are important causes of increased mortality, morbidity and cost of therapy among hemodialysis patients. Prevention of VARI requires the identification of predisposing risk factors. Sampling and Methodology: As per CDC guidelines, suspicion was made, and from them all possible samples were taken, 5-10 ml of blood both from Catheter and peripheral from patients with fever/rigors/hypotension. Exit-site swab when purulent discharge and Catheter tips (Suspected and non-suspected) removed aseptically for which semi-quantitative catheter tip culture by Maki's Roll plate method was done. This was followed by collection the samples inoculated into appropriate culture media plates and it was identified by its colony morphology and relevant biochemical reactions. Results: Out of 156, 61 were catheterized patients and 95 were AVF. Of which 28 were suspected based on CDC guidelines i.e., 21 from catheterized and 7 from patients with AVF. Based on nature of catheter used, the highest risk of infection was found in permanent catheters than temporary catheters. Based on anatomical catheter site, FVC was found to be at more risk of infection in our study with 60%.Polymicrobial growth was also seen in patient with FVC. Based on antibiogram, S.aureus, 2 out of 6 showed resistance to oxacillin and Enterococci, 1 out of 3 showed resistances to vancomycin and the only E. coli was found to be MDR type. Discussion: Vascular access related infections includes risk factors such as duration of catheterization maintenance which is more than the recommended days, increased preference of catheters than AVF due to late diagnosis of CKD and late referral to nephrologists and vascular surgeons for timely construction of AVF, anatomical site used. Also organisms in our study are mostly skin micro-organism found on patients and hands of health care workers, which indicates poor hand hygiene and inadequate or improper use of sterile technique. Our study's antibiogram result indicates the liberal usage of antibiotics.

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8. Snap, Crackle & Pop: A normal variant of increased insertional activity: May be misleading for electromyographer. Dahani G.S. JPMI - Journal of Postgraduate Medical Institute. 26 (3) (pp 340-342), 2012. Date of Publication: 2011. AN: 2012512282

Objectives: To describe the findings of Snap Crackle and Pop in different patients referred for electromyographic evaluation. Methodology: From August 2007 to December 2010 total of 2098 patients were referred to neurophysiology laboratory for evaluation in three different hospitals namely The Aga Khan University Hospital, Karachi, Pakistan, Liaquat University of Medical and Health Sciences, Jamshoro, Sindh, Pakistan and Armed Forces Hospital Southern Region, Khamis Mushayt, Saudi Arabia. Electromyography (EMG) needle examination was done by single electromyographer in the above mentioned hospitals. EMG findings were then confirmed by qualified consultant Clinical Neurophysiologist. Clinical information and EMG data were collected in text form. Results: Out of 2098 patients only 4 patients showed characteristic EMG findings of Snap Crackle and Pop. All 4 patients were male and they are giving history of vigorous exercise. All four patient exhibit abnormal insertional activity with diffuse positive sharp waves in different muscles. In one patient occasional fibrillation potentials were noted. Conclusion: Snap Cracle and Pop is rare disorder in male gender. Having characteristic EMG findings and can be misinterpreted easily.

Institution (Dahani) Department of Medicine, Armed Forces Hospital Southern Region, Khamis Mushayt, Saudi Arabia Publisher Postgraduate Medical Institute (Lady Reading Hospital, Peshawar, Pakistan)

9. Hemodialysis in children: A simplified approach. Gulati S., Lall N. Journal International Medical Sciences Academy. 25 (2) (pp 101-105), 2012. Date of Publication: April-June 2012. AN: 2012451634

Hemodialysis in children has benefited from major progress over the last 20 years. The morbidity of the sessions has decreased, even disappeared, seizures being exceptional, hypotensive episodes or headaches rare, and pain related to the fistula puncture effectively prevented by xylocaine ointment. The development of urea kinetic modeling enables calculation of the dialysis dose and indirect assessment of protein intake, nPCR. Even if the validity of these values is questioned their combined analysis provides an assessment and therefore is a "good thing". The patient also benefits from the technological revolution. The newer machines enable precise control of ultrafiltration volumetric assessment and continuous blood volume monitoring during the session, buffered bicarbonate has become a standard technique, synthetic more biocompatible membranes and specific material available for babies/infants have been developed. Non invasive intervention, for example blood volume guided ultrafiltration have provided more adequate dialysis sessions and better dry weight assessment . Last, the availability of erythropoietin and of growth hormone and the promising results from enhanced dialysis dose on both growth and cardiac function, all give the dialyzed child a real increased quality of life. In theory, reduction of dialysis prescription to only a urea dialysis dose achieved by three short (3-h) dialysis sessions, should be abandoned for long term dialyzed children and replaced by optimum dialysis obtained with longer (4 and more hours) and/or more frequent (daily: 5 to 6) sessions. But for such a daily dialysis strategy all the costs must be considered. On the one hand the financial cost cannot be neglected.

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and Escorts Hospitals, New Delhi, India Publisher International Medical Sciences Academy (Ansari Nagar, Ring Road, New Delhi 110029, India)

10. Are the NKF-KDOQI goals for vascular access in Mexico possible?. <Metas NKF-KDOQI para accesos vasculares en Mexico. Es posible?.> Garciduenas-Briceno C.M., Vega-Lafarga P.E., Vega-Ocegueda R., Salazar R.A. Revista Mexicana de Angiologia. 40 (1) (pp 37-40), 2012. Date of Publication: January-February 2012. AN: 2012264849

Introduction: The KDOQI guidelines recommend that autologous arteriovenous fistulae must be made in 65% of the patients suitables for hemodialysis, and at least 40% of the patients will use its fistulae as their vascular access. Objective: To report our experience in the application of a strategy for the creation of vascular access. Material and methods: We included 61 patients with chronic renal failure in hemodialysis. Patients with central venous catheters were scheduled for construction of autologous fistulae, we considered potential candidate to all patients. Results: Of the 61 included patients, 29 had a CVC and 12 an AVF. We constructed 29 fistulae in 27 patients. 26 antecubital, 2 radiocephalic and 1 humerobasilic. There were no major complications. 48% of the fistulas were used at the end of the study, this represent 65% of the fistulae of less than 6 weeks. Only nine patients had no fistula at the end of the study. Conclusions: We exceeded by 16% the goal of the NKF-KDOQI of 40% of patients dialyzed using autologous fistula.

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11. Patients in chronic hemodialysis: Report on practice patterns. <Pacientes en hemodialisis cronica: Reporte de patrones de practica.> Garciduenas-Briceno C.M., Enriquez-Vega E., Rodriguez-Jimenez O.A. Revista Mexicana de Angiologia. 40 (1) (pp 26-32), 2012. Date of Publication: January-February 2012. AN: 2012264848

Objectives: a) To determine practice patterns in the management of vascular access in patients currently on chronic HD, b) Whether practice patterns are agree to international standards. Material and methods: Transversal, descriptive, observational study. Was conducted in the Hemodialysis Service of Centro Medico Nacional La Raza. We included patients over 16 years, diagnosed with CKD that were in HD at our hospital. Data were gathered relating to the patient's medical history including kidney failure and vascular access. Results: We included 66 patients, 36 men and 30 women, average age 38 years. With an average of 72 months from diagnosis of CKD. 56.1% started on peritoneal dialysis and 43.9% on hemodialysis as replacement therapy of renal function. One patient started on hemodialysis with an arteriovenous fistulae, the rest started with a central venous catheter as vascular access, with average of its use of 9.3 months. Currently 26 (39.4%) have an autologous arteriovenous fistulae with an average use of 33 months. We found no factors significantly associated with the type of current

vascular access except months of replacement therapy (p = 0.036) and hemodialysis (p < 0.001). Conclusions: This study shows that the practice patterns of patients with chronic renal failure in our hospital are far from optimal management established by international guidelines.

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12. Management of chronic coronary disease and acute coronary syndromes in patients with chronic kidney disease. Narala K.R., LaLonde T.A., Hassan S., McCullough P.A. US Cardiology. 8 (2) (pp 123-132), 2011. Date of Publication: September 2011.

AN: 2012061921 Abstract coronary atherosclerosis is accelerated and highly prevalent among patients with chronic kidney disease (CKD). Acute coronary syndromes (ACS) are common in CKD and are a major source of morbidity and mortality in this population. The management of chronic coronary disease and ACS includes anti-ischemic agents, antiplatelet medications, anticoagulants, and medications that modify the natural history of myocardial remodeling after injury. In addition, revascularization, primarily with catheter-based techniques, is critical for optimal outcomes in moderate- and higher- risk patients. This article will review the array of treatments used in combination for stable coronary disease and ACS and will provide critical guidance concerning benefits, risks, and dose adjustments required for patients with baseline CKD.

Institution (Narala, LaLonde, Hassan, McCullough) St John Providence Health System, St John Hospital and Medical Center, Detroit and Providence Park Hospital, Novi, MI, United States Publisher Touch Briefings (Saffron House, 6-10 Kirby St, London EC1N 8TS, United Kingdom)

13. Peritoneoscopic insertion of peritoneal dialysis catheters by nephrologists. A single centre preliminary experience. Fourtounas C., Dousdampanis P., Hardalias A., Trigka K., Vlachojannis J.G. Hippokratia. 15 (SUPPL. 2) (pp 27-29), 2011. Date of Publication: 2011. AN: 2011681998

Background: Peritoneal Dialysis (PD) catheter has been characterized as the "lifeline" of PD patients. Timely and effective insertion of the PD catheter is essential for the success of a PD program. We describe our initial experience with peritoneoscopic implantation of PD catheters by nephrologists. Patients and Methods: Twenty-one patients underwent peritoneoscopic PD catheter implantation in our centre during 2007 - 2009. Their mean age was 57.3+/-14.7 years, 8 patients (38%) were transferred from hemodialysis and 12 patients (57%) had a previous history of uncomplicated abdominal surgery for various reasons. Results: All PD catheters were inserted under local anaesthesia in a nephrology ward. There were no major complications during, or

immediately after catheter implantation. There were 4 cases of eosinophilic peritonitis following air entrapment in the peritoneal cavity. PD fluid leak was observed in two cases and an abdominal hernia in one case. The PD catheter did not work properly in 3 cases and in two of them the catheter was removed and replaced by a new one by surgeons. During the follow up period a total of 5 catheters were removed: three of them after successful renal transplantation and two due to poor functioning. Conclusions: PD catheter insertion by nephrologists with peritoneoscopy is a rather simple, safe and efficient method. It offers the opportunity for timely initiation of PD and a relative independence from surgeons, reducing the waiting times and therefore enhancing PD uptake.

Institution (Fourtounas, Dousdampanis, Hardalias, Trigka, Vlachojannis) Department of Internal Medicine - Nephrology, Patras University Hospital, Rio-Patras, 26500, Greece Publisher Lithografia Antoniadis I - Psarras Th G.P. (19th Km, Thessaloniki - Polygyros Str., Nea Redestos 570 01, Greece)

14. The present and the future of Peritoneal Dialysis. Fourtounas C. Hippokratia. 15 (SUPPL. 2) (pp 15-20), 2011. Date of Publication: 2011. AN: 2011681996

Peritoneal Dialysis (PD) has been established as an effective renal replacement therapy complementary to hemodialysis (HD) for End-Stage Renal Disease (ESRD) patients. However, its prevalence has been decreasing during the last decades in Western Europe and USA, whereas in some regions such as Hong Kong or Mexico its penetration remains higher than 70%. These dramatic differences around the world can not be explained only by medical reasons. There are also many "hidden" factors such as financial issues (for profit HD), completely unproven dogmatic beliefs about the superiority of HD over PD, or more recently a fear about "the epidemic" of encapsulating peritoneal sclerosis in long standing PD. During the last two decades, there has been a significant progress in many fields of PD, such as reduced PD related peritonitis rates by new connectology systems, prevention of exit site infections by mupirocin or gentamycin ointments, wide application of automated PD by reliable cyclers, use of icodextrin for the long exchanges, better preservation of residual renal function, newer and more biocompatible PD solutions and timely placement of PD catheters by nephrologists. In addition, basic and clinical research is focusing on future improvements such as the use of two icodextrin exchanges per day, the application of new PD solutions with low sodium concentration, the wider use of "assisted" PD, and a better understanding of the pathogenetic mechanisms that may lead to peritoneal sclerosis with new therapies that may prevent it. The dilemma regarding the best modality for ESRD (HD or PD?) should be abandoned and the modern nephrologist should be wise enough to recognize the possible advantages and contraindications of each modality and confident enough to offer both of them to the ESRD patients as appropriate.

Institution (Fourtounas) Department of Internal Medicine - Nephrology, Patras University Hospital, Rio- Patras 26500, Greece Publisher Lithografia Antoniadis I - Psarras Th G.P. (19th Km, Thessaloniki - Polygyros Str., Nea Redestos 570 01, Greece)

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Problemstilling
Hvordan håndtere hemodialysekateter for å bevare kateterfunksjon og forebygge komplikasjoner?

Hvordan gi hemodialysepasienter trygghet i forhold til kateter som blodtilgang?

Problem/pasientgruppe	Intervensjon	Sammenligning	Utfall
Voksne og større barn over 35 kilo som behandles med	Kateterlås - Trisodiumsitrat (sitrat)	Kateterlås - Heparin	God kateterfunksjon - Forebygge

hemodialyse	Flushing-teknikk Bandasjer Hud-desinfeksjon teknikk og middel Aseptisk teknikk Hygienetiltak (munnbind, frakk, håndhygiene) Forebygge luftemboli - Luerlock - Leiring Pasientinformasjon Opplæring av personell	Non-touch teknikk	katetertrombose Unngå infeksjon Unngå luftemboli Gode pasienterfaringer Pasienttrygghet

EMNEORD

	Medline (MeSH)	**Embase**	**Tekstord**
P	(Renal dialysis) Catheterization Catheters	Hemodialysis Hemodialysis Patient Catheter atheterization	
I			
C			
O			

SØKESTRATEGI

Helsedirektoratet: lista skumlest

Nasjonalt nettverk for fagprosedyrer: lista skumlest
Vårdhandboken: lista skumlest
NHS NICE Pathways: lista skumlest
Nursing Reference Center: hemodialysis catheter
National Guideline Clearinghouse: hemodialysis catheter
Kliniske retningslinjer, Danmark: lista skumlest
NHS NICE Guidelines: hemodialysis catheter
SIGN: lista skumlest
Socialstyrelsen, Sverige: lista skumlest
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UpToDate: hemodialysis catheter
Clinical Evidence: hemodialysis catheter
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BMJ Best Practice, pasientinformasjon: hemodialysis catheter

Nursing Reference Center, pasientinformasjon: hemodialysis catheter

Sykehuset Innlandet, pasientinformasjon: hemodialyse

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Helsebiblioteket, pasientinformasjon: hemodialyse

Nel, pasientinformasjon: hemodialyse

MedlinePlus, pasientinformasjon: hemodialysis catheter

Nasjonalt informasjonssenter for alternativ medisin, pasientinformasjon: hemodialyse

Norsk helseinformatikk, pasientinformasjon: hemodialyse
Evidence-Based Nursing: ikke søkt her
Evidence-Based Medicine: ikke søkt her
Evidence-Based Mental Health: ikke søkt her
Evidence-Based Dentistry: ikke søkt her
McMaster PLUS, enkeltstudier: ikke søkt her
EHS Protocols: ikke søkt her
Helsebiblioteket, retningslinjer: lista skumlest
Medline, retningslinjer:

- 1 hemodialysis.mp. (51776)
- 2 catheter.mp. or exp Catheters/ (123774)
- 3 exp Catheterization/ or catheterization.mp. (210885)
- 4 2 or 3 (270203)

- 5 1 and 4 (4437)
- 6 limit 5 to yr="2011 -Current" (1066)
- 7 exp Practice Guideline/ (19850)
- 8 6and7(2)

Embase, retningslinjer:

- 1 exp hemodialysis/ or exp hemodialysis patient/ or hemodialysis.mp. (106202)
- 2 exp catheterization/ or catheterization.mp. (156009)
- 3 catheter.mp. or exp catheter/ (201343)
- 4 2 or 3 (299823)
- 5 1 and 4 (7664)
- 6 limit 5 to (exclude medline journals and yr="2011 -Current") (310)
- 7 exp practice guideline/ (329859)
- 8 6and7(14)

Cinahl, retningslinjer: hemodialysis catheter and practice guideline
NEL, Norsk elektronisk legehåndbok: hemodialyse
Medline, pasienterfaringer:

- 1 hemodialysis.mp. (51755)
- 2 catheter.mp. or exp Catheters/ (123703)
- 3 exp Catheterization/ or catheterization.mp. (210723)
- 4 2 or 3 (269994)
- 5 1 and 4 (4437)
- 6 limit 5 to "qualitative (maximizes specificity)" (9)

Embase, pasienterfaringer:

- 1 exp hemodialysis/ or exp hemodialysis patient/ or hemodialysis.mp. (106202)
- 2 exp catheterization/ or catheterization.mp. (156009)
- 3 catheter.mp. or exp catheter/ (201343)
- 4 2 or 3 (299823)

- 5 1 and 4 (7664)
- 6 limit 5 to (exclude medline journals and yr="2011 -Current") (310)
- 7 exp practice guideline/ (329859)
- 8 6and7(14)
- 9 limit 6 to "qualitative (best balance of sensitivity and specificity)" (17)

Medline: ikke søkt her
Embase: ikke søkt her

KOMMENTAR

Ingen kommentar.

BRUKERVEILEDNING

Fargekoder

Det vil være en grønn farge på de nivåene som er kunnskapsbaserte. Der det må kvalitetssikres er farget med rødt.

Praktisk

Bibliotektjenesten gjør litteratursøk til fagprosedyrer, behandlingslinjer og veiledende behandlingsplaner. Gjerne med representanter fra arbeidsgruppa. Litteratursøk skal bestilles av prosjektleder for kunnskapsbaserte fagprosedyrer i SI. Arbeidsgruppene kan gjøre litteratursøkene, men må være klar over minstekravene. Litteratursøket skal kvalitetssikres av bibliotekar hvis arbeidsgruppen gjør litteratursøket selv. Det er krav til dokumentasjon av litteratursøket og søkestrategi.

Teori

Brian Haynes kunnskapspyramide er utgangspunktet for hvordan vi utfører systematiske litteratursøk til fagprosedyrer. Brian Haynes utviklet denne 6S-modellen, som den kalles. Pyramiden ble utviklet ved McMaster universitetet i Canada, som er et internasjonalt arnested for kunnskapsbasert praksis. Ideen til Haynes er å søke etter kunnskap der den er gått gjennom en kvalitetskontroll først – slik at det man prioriterer først er å søke i kunnskapsbaserte retningslinjer, oppslagsverk, systematiske oversikter. Teorien til Haynes er også at hvis vi finner gode svar på spørsmålet vi måtte ha høyt oppe i pyramiden er det helt ok å stoppe der.

Det er ikke nødvendig å søke seg gjennom alle de relevante enkeltstudiedatabasene for å være sikker på å få nok svar. Det vil selvfølgelig være tilfeller hvor man ikke finner svar

øverst i pyramiden, og da må litteratursøkene helt ned til enkeltstudier. Vær oppmerksom på at de artiklene MÅ kvalitetssikres før de kan brukes.

Nasjonal metodebeskrivelse for systematiske litteratursøk

Den metoden Bibliotektjenesten i SI utfører litteratursøk er etter Nasjonal metodebeskrivelse for systematiske litteratursøk, som er utviklet av Bibliotekargruppa i Nasjonalt nettverk for fagprosedyrer. Alle foretakene som er med i dette nasjonale nettverket bruker denne metoden for å gjøre litteratursøk. Minstekravet er punkt 1---7 som er retningslinjer fra Helsedirektoratet, kunnskapsbaserte fagprosedyrer og retningslinjer i Norge og i andre land, samt kliniske oppslagsverk og systematiske oversikter av god kvalitet.

Punkt 1-6* er minstekravet:

- Nasjonale faglige retningslinjer fra Helsedirektoratet
- Kunnskapsbaserte fagprosedyrer utviklet innenfor Nasjonalt nettverk for fagprosedyrer
- Kunnskapsbaserte prosedyrer utviklet i andre land
- Norskspråklige retningslinjer (merket anbefalt i Helsebiblioteket)
- Kunnskapsbaserte utenlandske retningslinjer
- Kunnskapsbaserte kliniske oppslagsverk
- Kunnskapsbaserte systematiske oversikter (* Til og med Cochrane Reviews, er det lite treff kan det søkes i flere baser)

Metodebeskrivelsen finnes på www.fagprosedyrer.no

Krav til arbeidsgruppene

Som oftest vil ikke arbeidsgruppene utføre litteratursøkene selv. Men vi ønsker at dere bruker tid på spørsmålsformuleringen i forkant (gjerne også emneord) og at dere klarer å bruke litteratursøk-resultatet.

Selv om dere hovedsakelig ikke skal utføre litteratursøkene er det veldig viktig at dere vet hvordan og hvorfor bibliotekarene gjør som de gjør, og ikke minst at dere vet hvordan resultatskjemaet skal gås gjennom.

Når et litteratursøk fra bibliotektjenesten er ferdig vil dere få tilsendt en lenke av deres veileder. Alle litteratursøk skal bestilles elektronisk av veileder for fagprosedyrer i SI.

Artikler i fulltekst

I noen tilfeller vil det kun være lenke til abstrakt eller kun en enkel referanse. For å få tak i fulltekstversjonen er det et par ting du kan gjøre selv for å sjekke om SI har abonnement på dette tidsskriftet elektronisk.