Aims to demonstrate that a tunneled-cuffed catheter (TCC) implanted by a nephrologist is safe, effective and associated with excellent results.

METHODS: Retrospective study that analyzed 149 consecutive temporary-to-tunneled-cuffed catheter conversions in the operating room (OR) from a dialysis facility from March 2014 to September 2017. The data collected consisted of the total procedures performed, demographic characteristics of the study population, success rates, aborted procedure, failure in the procedure, complications observed, catheter survival and costs.

RESULTS: The main causes of end stage renal disease (ESRD) were systemic arterial hypertension and diabetes mellitus, 37.9% each. Patients had a high number of previous arteriovenous fistula (1.72 ± 0.84) and temporary catheter (2.87 ± 1.9) attempts until a definitive vascular access was achieved - the baseline characteristics of the patients are summarized on Table 1. The preferred vascular site was right internal jugular vein (80%). Success, aborted and failure rates were 93.3%, 2.7% and 4%, respectively, with only 5.36% complications (minors) - Table 2. Overall TCC survival rates over 3, 6, 12, and 24 months were 71.81%, 54.36%, 30.2% and 9.4%, respectively, with a mean of 298 ± 280 days (median 198 days). The procedures costs were around $496.

CONCLUSIONS: Our analysis shows that placement of TCC by nephrologist in an OR from a dialysis center is effectiveness, safety and results in substantial cost savings.

SP592 ARTERIOVENOUS GRAFT IN HEMODIALYSIS PATIENTS WITH IMPAIRED ACTIVITY OF DAILY LIVING

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INTRODUCTION AND AIMS: There is a worldwide surge in numbers of elderly people requiring hemodialysis accompanying the prevailing increase in longevity. With that background, we guess hemodialysis patients with impaired activity of daily living (ADL) are increasing. In addition, there is a trend for central venous catheters to be preferentially placed in these patients. Impaired ADL is recognized as a contributor to recurrent hospitalization and increased mortality. We reviewed our experience with arteriovenous graft surgery in all hemodialysis patients with impaired ADL, and evaluated the influence of ADL for loss of patency after AVG.

METHODS: In this single center retrospective study, we included 150 consecutive patients (150 upper limbs; age 73.8 ± 11.2; 47% male) who underwent forearm loop AVG formation from July 2014 to December 2016. Primary and secondary patency after AVG was evaluated by Kaplan-Meier analysis and predictors for loss of primary patency after AVG were determined using a Cox proportional hazards model. Partial or total dependence in transferring (requiring some help in moving in and out of bed/ chair or a complete transfer) were regarded as impaired ADL.

RESULTS: Results The median observation period was 21 months. The 1-year primary patency rate was 50.1%, and secondary patency rate was 90.2%. There was no significant difference in primary patency between non impaired ADL group and impaired ADL group (50.1% vs. 49.7% at 1 year, \(P = 0.305\)). In multivariate analysis, basilic vein usage as outflow anastomosis [hazard ratio, 0.58; 95% confidence interval, 0.36-0.98] was independently associated with operative predictor for primary patency after AVG. But impaired ADL [hazard ratio, 1.21; 95% confidence interval, 0.79-1.86] was not independently associated with operative predictor for primary patency after AVG.

CONCLUSIONS: There was no significant difference in primary patency between non impaired ADL group and impaired ADL group. Impaired ADL alone should not disqualify patients from arteriovenous graft surgery for hemodialysis.