SURGICAL & RADIOLOGICAL ENDOVASCULAR SYMPOSIUM
SRES
11-12 SEPT. 2025
• Radiologie Interventionnelle
• Chirurgie Vasculaire
• Chirurgie cardio-vasculaire et thoracique
• Médecine vasculaire
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MARSEILLE
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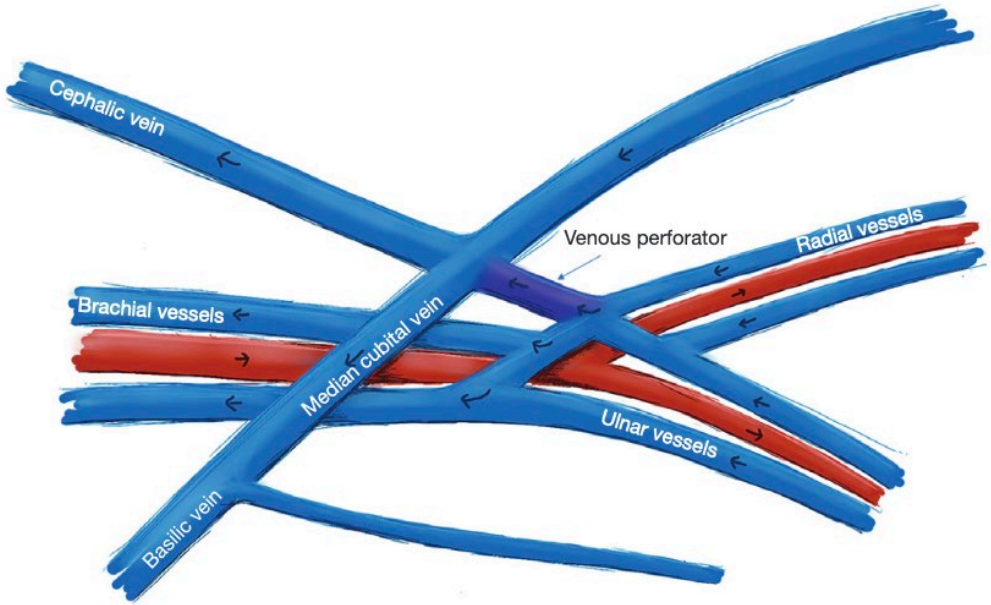
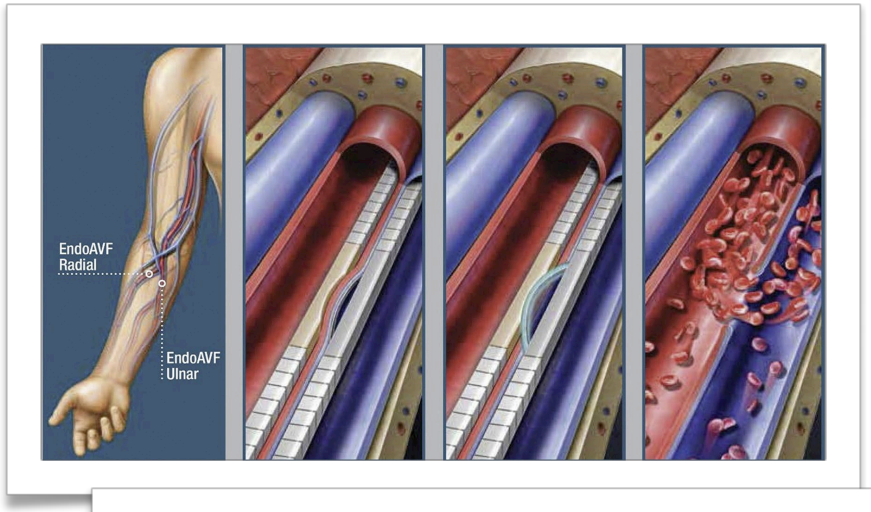


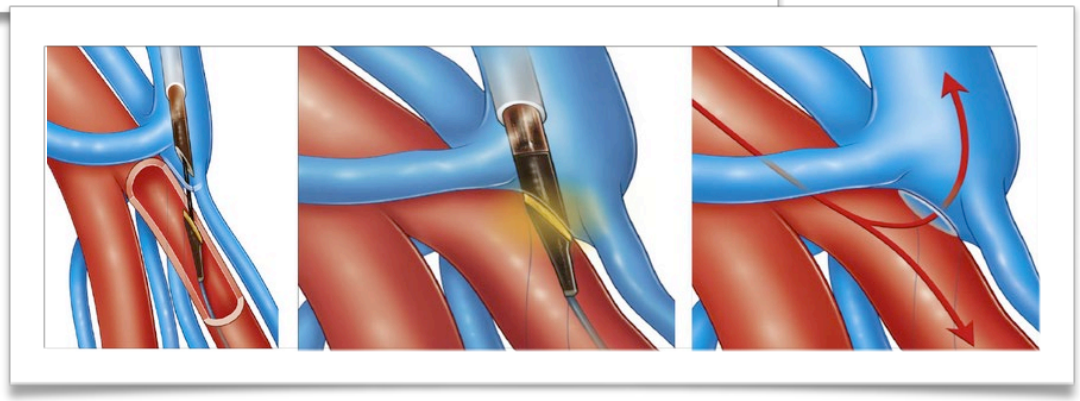
Création d'une FAV: les options en 2025

V. Brizzi

Imperial College, London, UK

Brescia et al. 1966





FAV idéale

Facilement réalisable

Facilement et rapidement utilisable

Performante (débit >300 ml/min)

Sure (risque cardiovasculaire ou infectieux bas)

Economique

Théorie

Editor's Choice — Vascular Access: 2018 Clinical Practice Guidelines of the European Society for Vascular Surgery (ESVS)☆

Jürg Schmidli [a,*], Matthias K. Widmer [a], Carlo Basile [a], Gianmarco de Donato [a], Maurizio Gallieni [a], Christopher P. Gibbons [a], Patrick Haage [a], George Hamilton [a], Ulf Hedin [a], Lars Kamper [a], Miltos K. Lazarides [a], Ben Lindsey [a], Gaspar Mestres [a], Marisa Pegoraro [a], Joy Roy [a], Carlo Setacci [a], David Shemesh [a], Jan H.M. Tordoir [a], Magda van Loon [a],

ESVS Guidelines Committee [b], Philippe Kolh, Gert J. de Borst, Nabil Chakfe, Sebastian Debus, Rob Hinchliffe, Stavros Kakkos, Igor Koncar, Jes Lindholt, Ross Naylor, Melina Vega de Ceniga, Frank Vermassen, Fabio Verzini,

ESVS Guidelines Reviewers [c], Markus Mohaupt, Jean-Baptiste Ricco, Ramon Roca-Tey

EJVS 2018

- Premier choix: FAV native

- Deuxième choix: pontage AV

- Troisième choix: accès veino-veineux (CVC)

Pourquoi ?

	FAV native	Pontage AV	CVC
Mortalité à 2 ans (%)	15	17	26
Infection (%)	1,3	4,7	5,7
Perméabilité primaire à 2 ans (%)	55	40	50
Satisfaction des patients	6,5	5,2	5,9

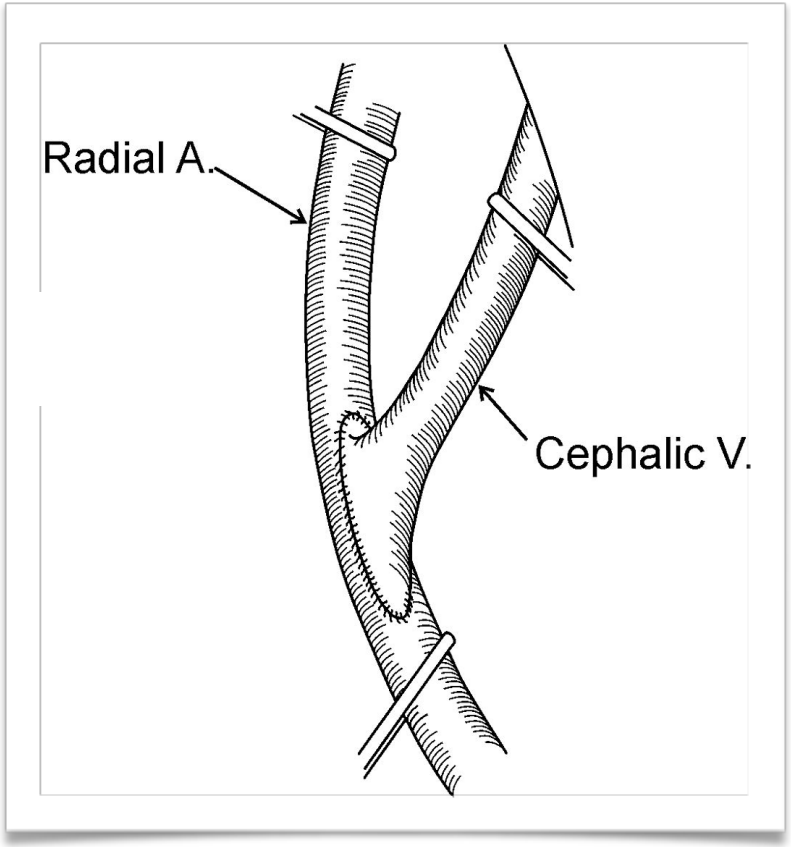
UK Kidney Association Clinical Practice Guideline on vascular access for haemodialysis

Emma Aitken[1], Hameed Anijeet[2], Damien Ashby[3*†], Wayne Barrow[4], Francis Calder[5], Brett Dowds[4], Catherine Fielding[6†], James Gilbert[7], Rob Jones[8], Narayan Karunanithy[5], Zaib Khawaja[8], Emma Roberts[9], Mike Robson[5,12], Rukshana Shroff[10], Hannah Stacey[11], Peter Thomson[1] and Dan Waters[4]

BMC Nephrology 2025

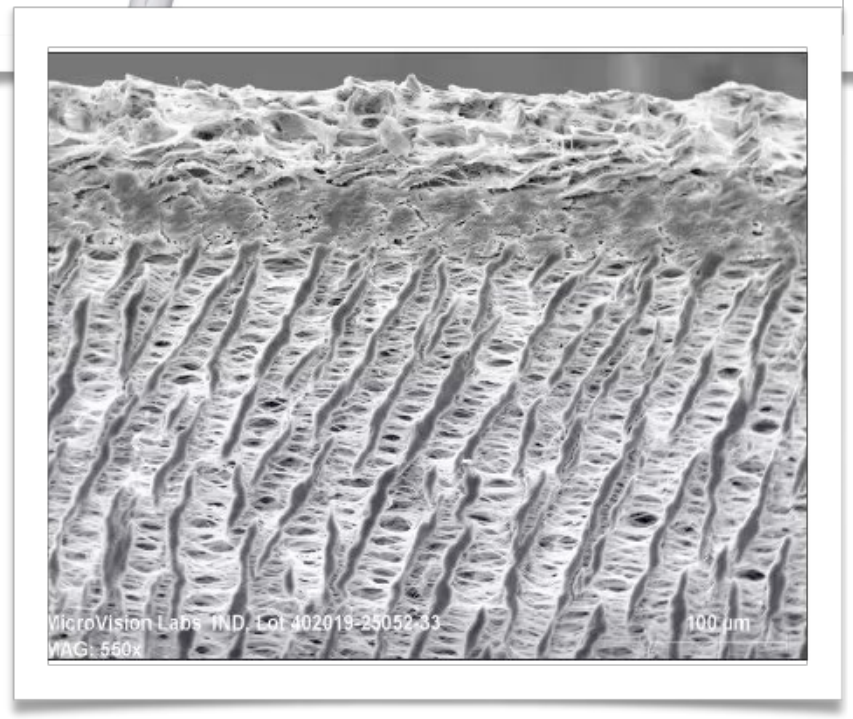
Technique (FAV)

- Distale +++
- Bras non dominant
- Diamètre > 2 mm (3 mm au coude)
- Artériotomie 5-6 mm
- Anastomose latéro-terminale
- Anesthésie loco-régionale



Technique (pontage AV)

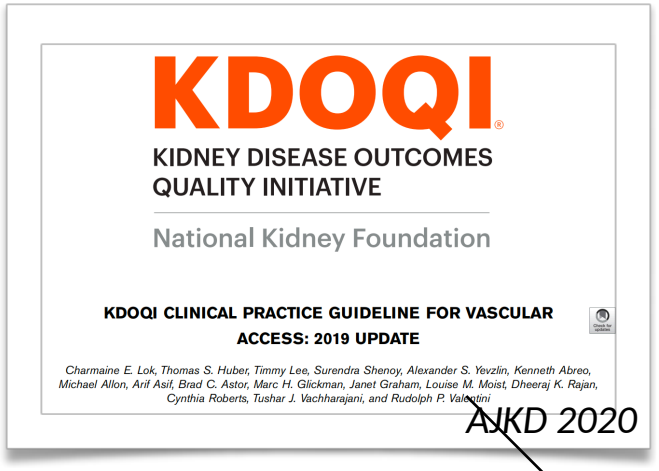
- Diamètre veineux > 3mm
- Prothèse ponction précoce
- Prothèse évasée
- Anse avant bras chez le patient obèse



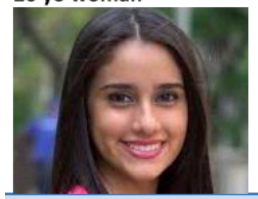
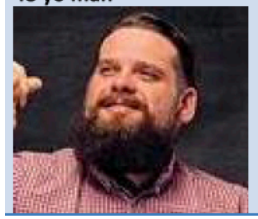
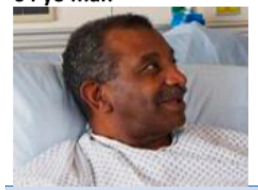
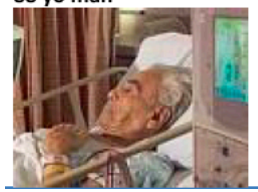
Vraie vie

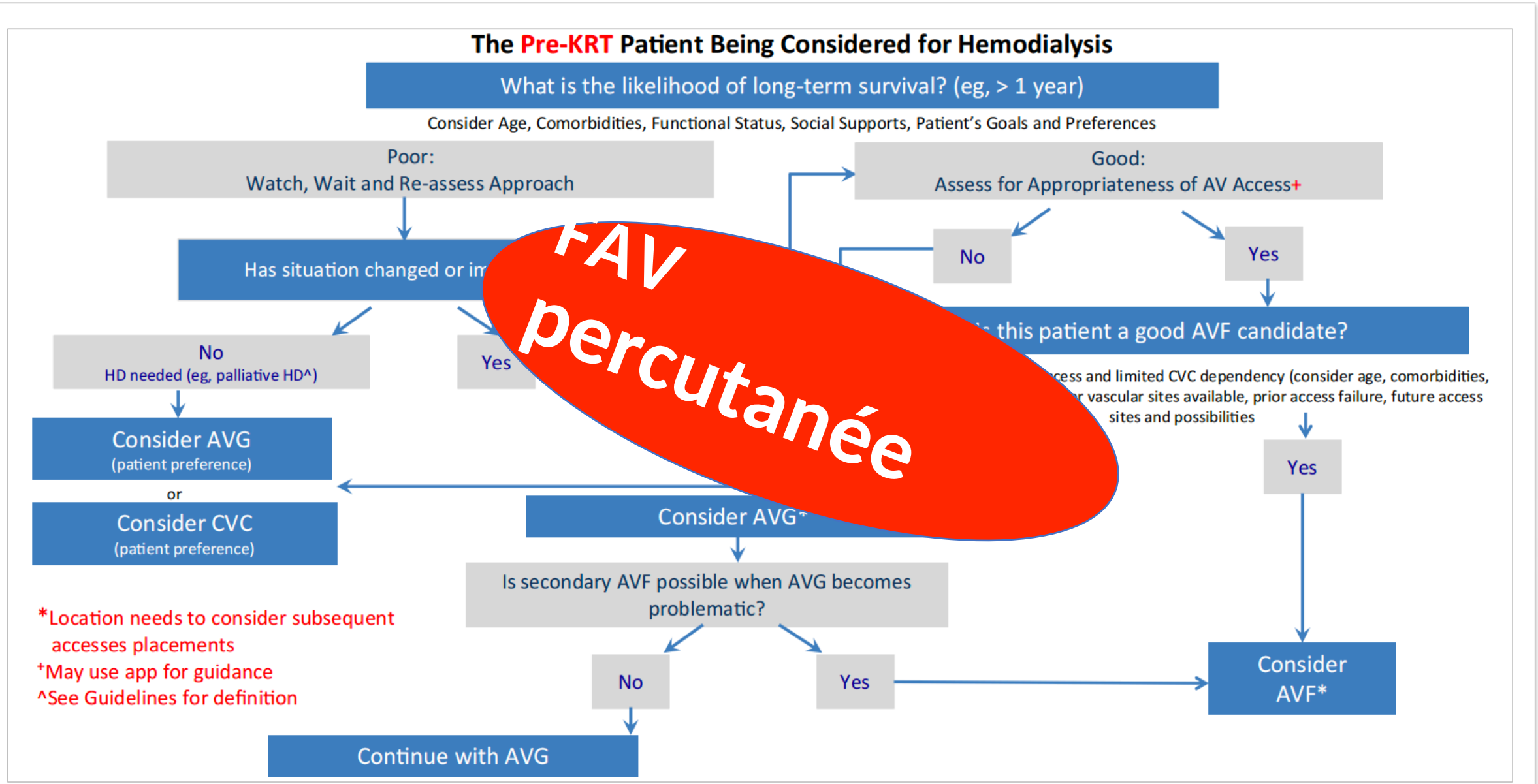
ESKD life plan

- Programme de vie avec la dialyse
- Multidisciplinaire + patient
- Mises à jour



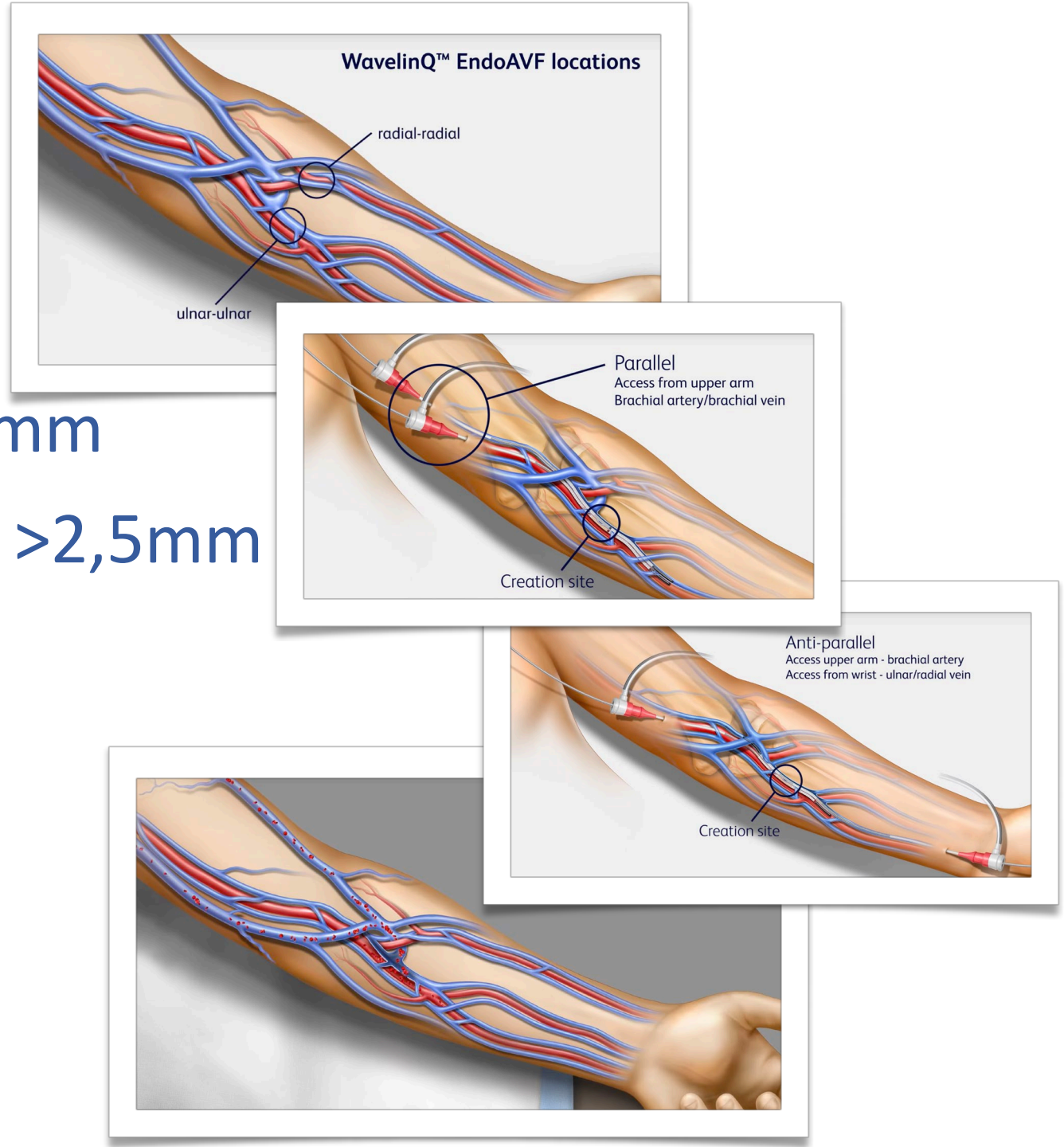
AJKD 2020

Case	Description	ESKD Life-Plan Modality Choice	Dialysis Access
14 yo girl 	Congenital cause of kidney damage, CKD nondialysis (eGFR 22 mL/min) has living donor for transplant, active – wants to be a teacher, right handed	1. Living donor transplant 2. PD 3. Home NHD	1. Transplant - NA 2. PD catheter 3. RC-AVF (left)
26 yo woman 	GN, on HD; failed PD with temporary CVC, has potential living donors, actively working during day, R hand dominant	1. Home NHD 2. Transplant	1. RC-AVF (left) 2. BC-AVF (left)
48 yo man 	DM, HTN, AFib, obese. Copes poorly and non-adherent to medical management and presented needing to urgently start HD, works in outdoor maintenance, L handed	1. IC-HD 2. Transplant wait list 3. PD may be possible later	1. Early cannulation forearm loop graft (right) 2. BC-AVF 3. PD catheter
64 yo man 	HTN, PCKD; ESKD on HD x7 years; R handed; Jehovah witness; sudden loss of RC-AVF (left)	1. IC-HD 2. PD may be possible	1. CVC (left, IJ) 2. BC-AVF (R) 3. PD catheter
77 yo woman 	Frail, DM, CAD, PVD, urgently started dialysis, with CVC, lives alone, R handed	1. IC-HD 2. PD may be possible	1. BC-AVF (left) 2. Upper arm graft (left) 3. PD catheter
88 yo man 	Palliative patient and very frail but still enjoys time with family	1. IC-HD	1. CVC (right IJ)


The Pre-KRT Patient Being Considered for Hemodialysis
What is the likelihood of long-term survival? (eg, > 1 year)
Consider Age, Comorbidities, Functional Status, Social Supports, Patient's Goals and Preferences
Poor:
Watch, Wait and Re-assess Approach
Has situation changed or im
No
HD needed (eg, palliative HD^)
Yes
Consider AVG
(patient preference)
or
Consider CVC
(patient preference)
Good:
Assess for Appropriateness of AV Access+
No
Yes
this patient a good AVF candidate?
cess and limited CVC dependency (consider age, comorbidities,
r vascular sites available, prior access failure, future access
sites and possibilities
Yes
Consider AVG*
Is secondary AVF possible when AVG becomes problematic?
No
Yes
Consider AVF*
Continue with AVG
*Location needs to consider subsequent accesses placements
+May use app for guidance
^See Guidelines for definition
FAV percutanée

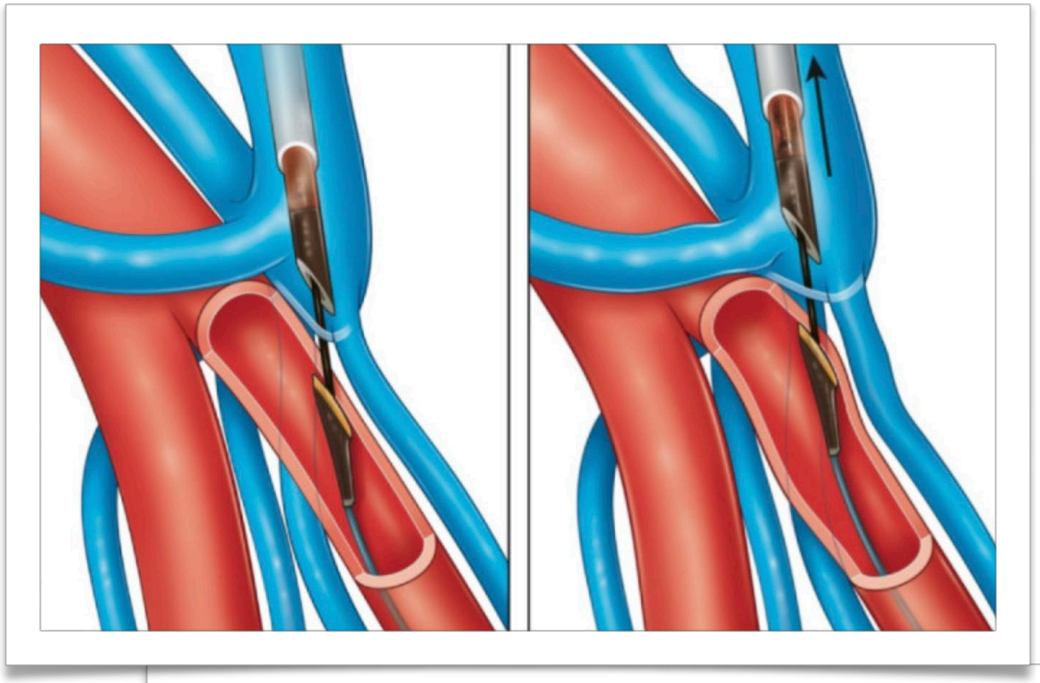
WavelinQ (BD)

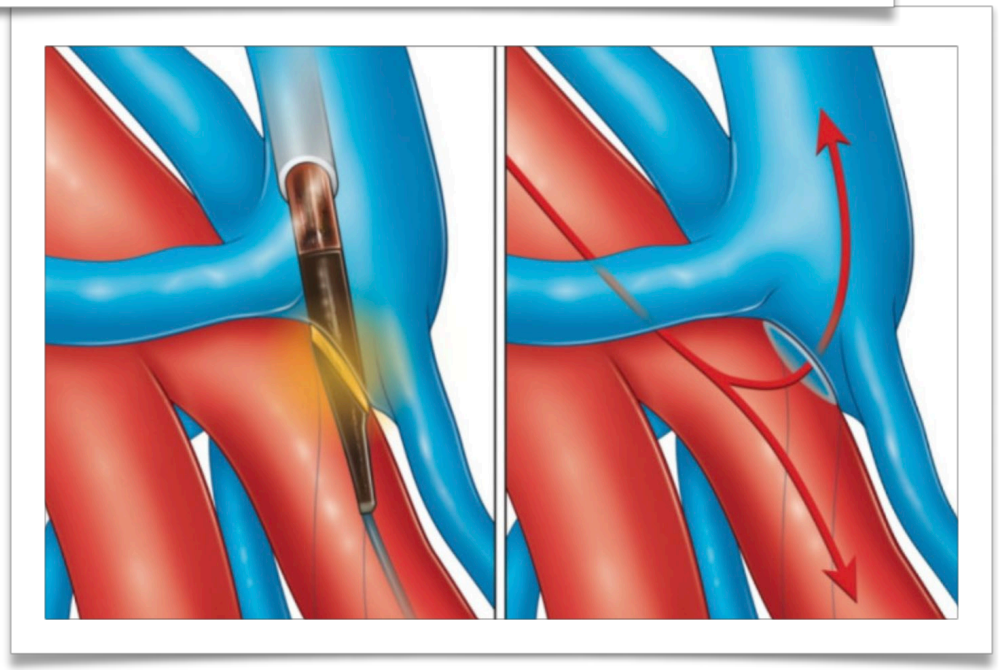
- Diamètre a. humérale >2mm
- Diamètre vv. de drainage >2,5mm
- Perforante >2mm
- 2 introducteurs 4F
- Fluoroscopie
- Radiofréquence
- Embolisation nécessaire



Ellipsys (Medtronic)

- Perforante peu tortueuse
- Distance avec l’artère <1,5mm
- 1 introducteur 6F
- Echo-guidage
- Energie thermique





Résultats

- Succès technique: >97%
- Perméabilité primaire à 1 an: 54 - 69%
- Perméabilité secondaire à 6 m: 81 - 85%
- Evénements indésirables: 0 - 8%

- Superposables à la chirurgie conventionnelle

Revision de la literature

JVS 2024

Cost-effectiveness analysis of endovascular vs surgical arteriovenous fistula creation in the United States

Bianca Mulaney-Topkar, MD, MS, MPH,[a] Vy T. Ho, MD, MS,[b] Michael D. Sgroi, MD,[b] Manuel Garcia-Toca, MD, MS,[c] *and* Elizabeth L. George, MD, MS,[a] *Boston, MA; Stanford, CA; and Atlanta, GA*

EndoAVF is not cost effective compared with s AVF when modeling 5 years outcome.

JVA 2021

Endovascular versus surgical creation of arteriovenous fistula in hemodialysis patients: Cost-effectiveness and budget impact analyses

Carla Rognoni[1], Matteo To

EndoAVF could be a cost saving strategy.

Study protocol for a French multicenter randomized controlled trial evaluating the medicoeconomic impact of Surgical vs Endovascular Arteriovenous Access Creation for Hemodialysis in End-stage Renal Disease (ENDO-FAV)

Caroline Caradu, MD, PhD,[a] Eric Ducasse, MD, PhD,[a] Edwin Ripoche, MD,[a] Audrey Cordon, MSc (Health Economics),[a] Antoine Bénard, MD, PhD,[a] *and* Alexandros Mallios, MD,[b] on behalf of the ENDO-FAV Collaborators, *Bordeaux and Paris, France*

Conclusion

« The right access, in the right patient,
at the right time, for the right reason »