HeRO® GRAFT NEWS BULLETIN

An Interventional Nephrologist's View on the HeRO Graft

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The interview was conducted by Lesley Dinwiddie, RN on Friday, January 4, 2013 in Raleigh, NC.

KEY TAKEAWAYS:

- "HeRO Graft is a necessary part of the vascular access options armamentarium…"
- "…HeRO Grafts do thombose at rates comparable to conventional grafts, but they are much easier to declot…"

1. "Dr. Hoggard, what are the compelling reasons that you and your colleagues refer patients for the HeRO Graft?"

"HeRO Graft is a necessary part of the vascular access options armamentarium especially for those patients who have run out, or are running out, of the conventional access options." He noted that there is no set recipe or algorithm to determine what is the best access for dialysis patients. While Dr. Hoggard agrees that fistulas do have the best overall outcomes, there are other considerations, especially patient comfort and prognosis. He cited the special case of frail elderly patients with loose and fragile skin who come to him in tears because their fistula is nearly impossible to cannulate unless they have an expert nurse or a spouse to create and use button holes. Dr. Hoggard said a conventional dialysis graft could be a better option, but frequently these patients have had multiple catheters and now have poor outflow as well. These patients could be candidates for a HeRO Graft.

Another example of the need for patient-centered assessment and planning Dr. Hoggard cited was the use of the HeRO Graft in the upper extremity before doing a conventional leg loop graft. "Mapping of the central vessels to determine point of access and assisting with placement of the HeRO Graft's Venous Outflow Component is a very important contribution of the interventionalist to the successful placement of a HeRO Graft. Being able to save the femoral vessels, not only helps the patient with a future access if necessary, but also prevents potential lower limb disability."

A key benefit that Dr. Hoggard appreciates about the HeRO Graft is the absence of a venous anastomosis, and therefore, absence of venous disease as a result. "And yes, HeRO Grafts do thrombose at rates comparable to conventional grafts, but they are much easier to declot than a conventional graft. That being said," he added, "the HeRO Graft is not for everyone who fails an access. There is no point in putting one in a patient whose cardiac function cannot support a conventional graft – with or without anticoagulant therapy." He recommends a cardiac workup for those patients at risk for cardiac compromise. But, he also noted that for those patients who were suitable for a HeRO Graft, the obvious benefits of reducing infection and increasing adequacy of dialysis far outweigh the complications of access thrombosis.

2. "Dr. Hoggard, how does the interdisciplinary team approach work in your practice especially for access-challenged patients? Specifically, this would include your collaboration with other disciplines to assess, plan, create, and manage a working vascular access."

In describing his assessment and practice methodology, Dr. Hoggard believes that the interventional nephrologist plays a key role in the access decision making and management since he or she receives the referrals of patients with long term catheters, requests for vessel mapping, and/or requests to evaluate failing fistulas or grafts that are unable to deliver enough flow consistently for adequate dialysis.

Dr. Hoggard said, "Having a knowledgeable and experienced vascular access coordinator is essential especially for those elderly and very disabled patients. I have to know what the history and goals are for each patient. So many of them have no idea why they have come to see me." He continued to explain that once the interventional assessment is done, having an experienced surgeon to communicate with and refer to for timely surgery is optimal. Communication between the team is rarely in person, but it is effective either by email, text, sometimes phone, and if there is sensitive patient information and studies, the faxing of an electronic file is efficient and HIPAA approved.

3. "Dr. Hoggard, what misconceptions have you heard of in relation to the utilization of the HeRO Graft or seen in the referrals of patients sent to you with the idea of them being HeRO Graft recipients?"

Dr. Hoggard does not perceive any misconceptions about the HeRO Graft. He said, "It just needs to be on the dashboard and remembered as an excellent choice for those select patients that we have discussed."

4. A final question posed to Dr. Hoggard was about the reimbursement for managing the malfunctioning or thrombosed HeRO Graft.

He responded that since the HeRO Graft thrombectomies are so uncomplicated (due to the lack of a venous anastomosis) and require very little equipment or time, he believes that the reimbursement is appropriate.

KEY TAKEAWAYS:

- "...the interventional nephrologist plays a key role in the access decision making..."
- "…[HeRO Graft] needs to be on the dashboard & remembered as an excellent choice…"
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