Letter to the Editor

Public–private collaboration in the gestion of hemodialysis vascular access

Colaboración público-privada en la gestión del acceso vascular para hemodiálisis

Dear Editor,

The native arteriovenous fistula (nAVF) is the vascular access (VA) of choice for haemodialysis (HD) as opposed to central venous catheters (CVC).\(^1,2\) Outcomes can be influenced by organisational and resource management factors.\(^3,4\) The high use of CVC in units is a long-standing problem,\(^5,6\) worsened by the COVID-19 pandemic,\(^7\) during which elective surgeries, including VA,\(^8\) were postponed and the public health service failed to resolve the problems of delayed interventions in all specialist areas.\(^9\) The high proportion of CVC makes it necessary to devise strategies to reverse this situation. From July 2021 at the Lalín centre, attached to Hospital de Santiago, an agreement was established that stipulated that the centre was responsible for the creation of VA which did not require hospital admission for patients in its area, including patients with advanced chronic kidney disease (ACKD). The hospital took care of VA requiring hospital admission (prosthesis or basilic superficialisation)\(^5,\)\(^6\); of patients who were dialysed at the centre from October 2020 to February 2022; 24 (53.3%) had CVC. Ten patients were assessed for nAVF at the external centre. Four patients were referred to the referral hospital; two because they required inpatient techniques and two refused the referral to the outpatient centre. Six autologous nAVF were performed at the external centre (two radiocephalic and four elbow nAVF), all of which were functional. The average time from mapping at the outpatient centre was 10.5 days and from mapping to surgery 11 days; at the hospital it was 73 days. The percentage of catheters decreased and the percentage of fistulae increased significantly in prevalent patients at the centre (Table 1). VA surgery does not require hospitalisation or general anaesthetic,\(^10\) so it can be performed at outpatient surgery centres outside hospital circuits, speeding up the intervention and not interfering with (or being interfered with by) more urgent or complex disorders. The strategy of combining resources and managing public and private capacities jointly from the referral hospital offers a valid and effective alternative to improve outcomes within a very short time, with the greatest safety.

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**Table 1 – Percentage of prevalent patients with CVC or nAVF/prosthesis at the end of the two study periods.**

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<thead>
<tr>
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<th>Period 1: 1/October/2020 to 30/June/2021, before the start of the public-private partnership</th>
<th>Period 2: 1/July/2021 to 28/February/2022, after the start of the public-private partnership</th>
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<tbody>
<tr>
<td>Central venous catheter</td>
<td>26 (55.6%)</td>
<td>12 (26.7%)</td>
<td>&lt;0.001</td>
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<tr>
<td>Native fistulae/prosthesis</td>
<td>20 (44.4%)</td>
<td>34 (73.3%)</td>
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nAVF: native arteriovenous fistula.

**REFERENCES**


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