Review Article

The importance of anesthesiological methods in the creation of arteriovenous fistulas

Radojica V. Stolić1*, Snezana Markovic-Jovanovic2, Vladan Perić2, Vekoslav Mitrović3, Goran Relić2, Kristina Bulatović2, Saša Sovtić2, Branka Mitić4

1University of Kragujevac, Serbia, Faculty of Medical Sciences, Department of Internal Medicine, Serbia
2University of Pristina/K.Mitrovica, Serbia, Medical Faculty Pristina/K.Mitrovica, Serbia
3University of East Sarajevo, Faculty of Medicine Foca, Republika Srpska, Bosnia and Herzegovina
4University of Niš, Serbia, Faculty of Medicine, Serbia

Received: 12 December 2020
Accepted: 21 January 2021

*Correspondence:
Dr. Radojica V Stolic,
E-mail: radsto@ptt.rs

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

INTRODUCTION

The number of patients with terminal renal failure in the world is constantly increasing, and the estimated annual material costs per patient for their medical care reach 180,000 dollars. Arteriovenous fistulas are the preferred model of the vascular access for the treatment of chronic hemodialysis. Compared with tunneling central venous catheters and vascular grafts, arteriovenous fistulas have a lower risk of systemic sepsis and of all causes of cardiovascular mortality. There was a significant initial rate of early complication of radiocephalic arteriovenous fistulas, due to thrombosis, inadequate blood flow and/or insufficient maturation. Interventions to maintain vascular access to hemodialysis cost $600 million annually in the United States. Fistula maturation is associated with significant preoperative (arterial and venous diameter) and postoperative (blood flow through arteriovenous fistulas) parameters, patient characteristics, and surgical techniques. Therefore, a large number of research efforts are focused on these factors to improve the patency rate of the fistula.1–6

ABSTRACT

All anesthesia procedures represent a real danger to life in patients with renal insufficiency, which is why these patients are classified in category IV, so anesthesia procedures for this population are adjusted depending on their individual characteristics. Although local and general anesthesia are acceptable modalities for arteriovenous fistula formation, it is known that local anesthesia is associated with tissue reduction and edema, which may be associated with reduced electrocautery efficiency, increased risk of infection, and vasospasm, especially with repeated injections. It must be noted that there is no consensus on whether an arteriovenous fistula should be created under local, regional, or general anesthesia. Still, it is considered that regional block anesthesia provides reduced vasospasm of blood vessels, provokes venodilatation and complete sensory and blockade of motor neurons, as well as higher primary functional rates in the first 3 months, since its creation, compared with local anesthesia. Overall, patients with end-stage renal disease are a group of patients with a wide range of comorbidities which, along with chronic kidney damage, increase the risk of perioperative anesthetic complications, especially when subjected to general anesthesia. Therefore, alternative modes of anesthesia, such as local and regional blockade, could bring obvious benefits to these patients. It can be concluded that the choice of anesthesia method is determined by several interrelated factors, anesthesiologist, patient and the surgeon, which implies expertise, inclination, habits, practicality, and norms.

Keywords: Anesthesiology, Arteriovenous fistula, Local anesthesia, Regional block anesthesia, General anesthesia
It has long been thought that anesthesia techniques can affect the rate of blood flow through arteriovenous fistulas and the success rate.\(^6\)

It must be pointed out that all anesthesia procedures represent a real danger to life in patients with renal insufficiency. Therefore, the American Association of Anesthesiologists has classified patients with end-stage renal disease in category IV, along with severe systemic diseases, so anesthesia procedures for this population are adjusted depending on their individual characteristics.\(^7,8\)

**PHARMACOKINETICS OF DRUGS**

The interaction between end-stage renal disease and anesthetic drugs depends not only on renal excretion but also on the pharmacokinetics of the drug. Due to permanent hypervolemia in these patients, there is a reduced concentration of plasma proteins, which are therefore less available for drug binding and transport. The degree of drug ionization will also be affected by chronic metabolic acidosis, which in combination with hypalbuminemia and low plasma proteins increases the concentration for those drugs that have a higher affinity for protein binding.\(^9\)

In patients with end-stage renal disease, the pharmacokinetics of the drug are altered, especially anesthetics (Table 1), therefore the doses of thiopental and benzodiazepines should be reduced by 30-50%. The pharmacokinetics of propofol do not change in renal failure, but there is some evidence to suggest that patients with established renal insufficiency require higher initial doses to achieve the same level of hypnosis. This must be balanced with frequent cardiovascular comorbidities and patient instability. Inhaled agents are ideal for maintaining general anesthesia, because they are excreted through the lungs. As most opioids are metabolized in the liver, renal disease is not considered to affect the pharmacokinetics and dynamics of drug administration. However, morphine has active metabolites (morphine-6-glucuronide) that are excreted by the kidneys and are prone to accumulation and toxic effects, so doses should be reduced or alternatives found. Oxycodone is widely used in patients with impaired renal function, because the prolongation of the effect that can be attributed to the accumulation in renal insufficiency is much less pronounced. Fentanyl's rapid onset and deviation combined with the lack of active metabolites makes it more suitable for postoperative use if necessary. Suxamethonium may cause an increase in serum potassium, which should be taken with caution in these patients who already show relative hyperkalemia. Most non-depolarizing muscle relaxants are excreted unchanged by the kidneys, so doses should be reduced. Rocuronium relies in part on renal excretion and as such shows prolonged action in renal failure.\(^9\)

Local anesthetics are extremely useful drugs in surgical interventions in patients with chronic renal failure. In end-stage renal disease, metabolic acidosis reduces both the duration of anesthetic action and plasma protein binding, which increases the possibility of toxicity, so maximum doses must be reduced by 25%. Esters are hydrolyzed in plasma, while amides undergo liver metabolism, so renal excretion does not affect their function. Performing neuroaxial blockade and possibly peripheral regional blocks may be contraindicated, which in turn may pose an increased risk for patients in need of general anesthesia.\(^9\)

**INFLUENCE OF TYPE OF ANESTHESIOLOGICAL TECHNIQUE ON CREATING AN ARTERIOVENOUS FISTULA**

Species of anesthesia used to create arteriovenous fistulas can play an important role in the maturation and long-term patency of an arteriovenous fistula. In addition to very demanding general anesthesia, which is recommended only in special circumstances, other anesthesia techniques are available for the creation of arteriovenous fistulas. The use of local anesthesia is an extremely desirable method, which does not require the mandatory presence of an anesthesiologist, which is why the formation of a vascular access can be organized on an outpatient basis. Local anesthesia is associated with tissue reduction and edema, which may be associated with reduced electrocautery efficiency and increased risk of infection. Variable degrees of vasospasm also occur during this procedure, especially with repeated injections. Yet, it is common for anesthesia to be chosen by the operating surgeon, regardless of the effect that anesthesia may have on the degree of maturation.\(^10\)

**INFLUENCE OF ANESTHESIA ON SYSTEMIC CIRCULATION**

Regional block anesthesia provides reduced vasospasm of blood vessels, provokes venodilatation and complete sensory and blockade of motor neurons in the area distal to the middle upper arm. A prospective study evaluated the effect of the axillary nerve block for site selection to create an anastomosis and found an increase in the rate of initial functioning of the arteriovenous fistula when regional blockade due to consecutive venodilatation is used. Complications associated with regional block anesthesia include pneumothorax, hematoma, intravascular, epidural, or subarachnoid injection, and rare nerve damage. Side effects include temporary paralysis of the phytin nerve and Horner's syndrome. A unilateral block of the phrenic nerve is unlikely to create a problem if the patient does not have a respiratory disease. The benefits of regional block are well documented and include anesthesia of the entire upper extremity, block of motor function during the procedure, and venodilatation. Regional block, unlike local anesthesia, results in reduced tissue edema resulting in improved electrocautery efficiency and reduced risk of infection. A review of the literature published in 2009, indicates better postoperative analgesia and faster recovery from...
anesthesia. Shorter time for surgery and reduced intraoperative pain are also observed, compared to local anesthesia. Arterial vasodilation occurs due to sympathetic block with subsequent reduced resistance and improved blood flow through the upper arm. Long-term effects are unknown, however, associated venodilation, as a consequence of regional block anesthesia, has been shown to last over five hours. Increased blood volume through the extremity and perioperative venodilation, even if short-lived, may play an important role in the early remodeling of a newly formed fistula. Venodilation after brachial plexus block can provide an accurate estimate of vein diameter, during the operation itself.9,10

In a study by Reynolds et al. the application of regional block anesthesia increased the rate of initial arteriovenous fistula function from 89% to 93%. The long-term effects of brachial plexus block on fistula patency are unknown, but a tendency of the venous conduit of the arteriovenous fistula to form an aneurysm has been established.10

Although local, general or regional anesthesia are acceptable modalities for arteriovenous fistula formation, the accumulation of evidence suggests that regional anesthesia in the form of a brachial plexus block is associated with significantly increased blood flow through the arteriovenous fistula as well as higher primary functional rates in the first 3 months compared with local anesthetic infiltration.9,10

INFLUENCE OF ANESTHESIA ON THE LENGTH OF FUNCTIONING OF ARTERIOVENOUS FISTULAS

Meta-analysis data show that regional anesthesia results in venous dilatation and sympatholytic effects, that is, an increase in diastolic blood flow and a decrease in peripheral arterial resistance Aitken et al measured blood flow through the brachial artery before and immediately after anesthesia.11 They found that regional, unlike local anesthesia, was associated with increased blood flow through the brachial artery. Moukuet et al indicated a significant increase in blood flow in the brachial artery after block anesthesia, compared with local anesthesia.12

Shoshiashvili et al performed randomized local and regional block anesthesia in 103 patients and found that regional anesthesia was associated with significantly shorter operative times and lower analgesic needs.13 The supraclavicular regional technique blocks both the ulnar and musculoskeletal nerves, which increases the rate of functionality compared to interscalenic and axillary approaches. Moreover, when performed under ultrasound control, this procedure appears safe, with a low rate of complications, such as toxicity from local anesthetics, direct nerve injury, pneumothorax, and hematoma. Rare but serious complications can occur, especially when the local anesthetic solution is inadvertently injected into a blood vessel or absorbed in high doses, which can result in systemic neurotoxicity or cardiotoxicity. Local anesthesia is performed without guidance, can be complicated by accidental nerve perforation and result in vasospasm or hematoma formation. This risk is higher in obese patients with deeply located veins.6

REGIONAL BLOCK OR LOCAL ANESTHESIA

Systematic review and meta-analysis from four single-center randomized controlled trials showed that the use of regional block anesthesia for arteriovenous fistula surgery was associated with improved fistula functionality, compared with local anesthesia. Administration of regional block anesthesia requires the presence of an appropriately trained anesthesiologist and lasts longer than local anesthesia. Although the available evidence suggests that regional block anesthesia is useful, only large multicenter randomized controlled trials can provide sufficient evidence to change guidelines and practice. Renal Association Clinical Practice Guideline on Haemodialysis for vascular access to hemodialysis do not include recommendations on anesthesia technique, and recent European Society of Vascular Surgery guidelines recommend that regional block anesthesia be primarily recommended for local anesthesia, level of evidence B. Barriers to the use of brachial plexus block versus local anesthesia, as research and qualitative findings show, including surgeon's decision, time constraints and lack of anesthesiologists to perform block anesthesia, shifts toward regional anesthesia, appear to be facilitated by the perception of improved outcomes, with anesthesiologists often recognized as drivers of these changes. The choice of anesthesia modality shows the complexity of anesthesia as an intervention and that the choice of anesthesia method is determined by several
interrelated factors that include not only the anesthesiologist, but also the patient and the surgeon. Decisions about the mode of anesthesia depend on a number of interrelated factors, including expertise, inclination, habit, practicality, and norms.14

ANESTHETIC METHODS FOR CREATING ARTERIOVENOUS FISTULA: STILL THERE IS NO CONSENSUS

The most commonly used local anesthetics belong to the group of amino esters and amino amides, and they all cause blockade of nerve impulses. By adding vasoconstrictors (adrenaline, phenylephrine) their effect and duration is prolonged.15 The regional anesthesia technique allows for less hemodynamic variation and reduces the risk of aspiration. Analgesic sedation increases the risk of apnea, aspiration and hypoxia and therefore the anesthesiologist must always be prepared to translate regional anesthesia into general.16 To create an arteriovenous fistula, the most commonly used are: infiltration of a local anesthetic, blockade of peripheral nerves, blockade of the brachial plexus and axillary block anesthesia.

Table 1: Characteristics of individual anesthetics used in infiltrative anesthesia.17

| Types of the drug | Common concentrations | Ordinary solution | Epinephrine-containing solution |
|-------------------|-----------------------|-------------------|-------------------------------|
|                   |                       | Maximum doses (mg) | Duration of anesthesia (min) | Maximum doses (mg) | Duration of anesthesia (min) |
| Estri             |                       |                   |                               |                   |                               |
| Procain           | 1.0                   | 1000              | 30-60                         |                   |                               |
| Chlorprocain      | 1.0-2.0               | 800               | 30-45                         | 1000              | 30-90                         |
| Amidi             |                       |                   |                               |                   |                               |
| Lidocain          | 0.5-2.0               | 300               | 30-120                        | 500               | 120-360                       |
| Mepivacain        | 0.5-1.0               | 300               | 45-90                         | 500               | 120-360                       |
| Prilocain         | 0.5-1.0               | 500               | 30-90                         | 600               | 120-360                       |
| Bupivacain        | 0.25-0.5              | 175               | 120-240                       | 225               | 180-420                       |
| Ropivacain        | 0.2-1.0               | 300               | 360-600                       | Not used          |                               |
| Etidocain         | 0.5-1.0               | 300               | 120-180                       | 400               | 180-420                       |

In most institutions, local anesthesia is used to create arteriovenous fistulas in the area of the wrist and forearm (Table 1). This procedure is often supplemented with intravenous narcotics from the group of barbiturates or benzodiazepines, which can cause complications, which in the postoperative course prolong their recovery in the intensive care unit.16

The musculocutaneous and medial antebrachial nerves of the skin can be anesthetized by peripheral infiltration, the so-called blockade of peripheral nerves. This technique is well accepted for the creation of an arteriovenous fistula in the forearm region, it is relatively easy to perform, and the need for high doses of local anesthetics is avoided. Brachial plexus block in the supraclavicular region is a procedure used for planned surgery on the upper extremity, any region. This anesthesia is limited to patients who can move their arm by 900, but often requires additional infiltration of local anesthetics, especially for the upper arm. Complications that may occur after the application of block anesthesia are hematoma, nerve damage, perforation of blood vessels, pneumothorax and arteriovenous insufficiency.15,17

CONCLUSION

All anesthesia procedures represent a real danger to life in patients with renal insufficiency, therefore it is necessary to plan and adapt them to their condition. It is important to know the pharmacokinetics of drugs used in anesthesia as well as all anesthetic techniques used in patients with end-stage kidney disease. In addition to very demanding general anesthesia, local anesthesia is an extremely attractive method, so be the formation of a vascular access can be organized on an outpatient basis. Local anesthesia is associated with tissue reduction and edema, which may be associated with reduced electrocautery efficiency and increased risk of infection. Regional block anesthesia provides reduced vasospasm of blood vessels, provokes venodilatation and complete sensory and blockade of motor neurons, which affects the increase in flow rate, and of initial functioning of the arteriovenous fistula. Yet, there is still no consensus regarding the application of the anesthesia technique for creating an arteriovenous fistula. It can be concluded that the choice of anesthesia method is determined by several interrelated factors, anesthesiologist, patient and the surgeon, which implies expertise, inclination, habits, practicality, and norms.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Stolic R. Most Important Chronic Complications of Arteriovenous Fistulas for Hemodialysis. Med Principles Pract. 2013;22:220-28.
2. Stolic R, Grbic R, Odalovic D, Smilic L. Hemodynamic changes conditioned by arteriovenous fistulas for hemodialysis. Ital J Vasc Endovasc. 2015;22(3):153-8.

3. Stolic R, Trajkovic G, Kostic M, Lazic B, Odalovic B, Smilic T et al. Cannulation Technique and Arteriovenous Fistula Survival in Elderly Patients on Hemodialysis. Nephrol Nurs J. 2017;44(5):441-46.

4. Stolic R, Trajkovic G, Kostic M, Mihailovic B, Jovanovic A, Lazic B, et al. Factors affecting the patency of arteriovenous fistulas for hemodialysis: Single center experience. Hemodialysis International. 2018;22:328-34.

5. Stolić R. Dysfunction of the arteriovenous fistula for hemodialysis as a consequence of venous neointimal hyperplasia and treatment strategies. Srp Arh Celok Lek. 2019;147 (9-10):642-48.

6. Cerneviciute R, Sahebally SM, Ahmed K, Murphy M, Mahmood W, Walsh SR. Regional Versus Local Anaesthesia for Haemodialysis Arteriovenous Fistula Formation: A Systematic Review and Meta-Analysis. Eur J Vasc Endovasc Surg. 2017;53:734e742.

7. Ramirez MP, Berman SS. Anesthetic Considerations. In: Berman SS, eds.Vascular access in clinical practice. Tucson, Arizona. 2002:15-31.

8. Elsharawy MA, Al-metwalli R. Does regional anesthesia influence early outcome of upper arm arteriovenous fistula? Saudi J Kidney Dis Transpl. 2010;21:1048-52.

9. Bradley T, Teare T, Milner Q. Anaesthetic management of patients requiring vascular access surgery for renal dialysis. BJA Education. 2017;17(8):269-74.

10. Reynolds TS, Kim KM, Dukkipati R, Nguyen TH, Julka I, Kakazu C, et al. Pre-operative regional block anaesthesia enhances operative strategy for arteriovenous fistula creation. J Vasc Access. 2011;12(4):336-40.

11. Aitken E, Jackson A, Kearsn R, Steven M, Kinsella J, Clancy M, et al. Effect of regional versus local anaesthesia on outcome after arteriovenous fistula creation: a randomised controlled trial. Lancet. 2016;388:1067e74.

12. Mouquet C, Biterk MO, Bailliart O, Rottembourg J, Clergue F, Montejo LS, et al. Anaesthesia for creation of a forearm fistula in patients with endstage renal failure. Anesthesiology. 1989;70(6):909e14.

13. Shoshiashvili V, Tataradze A, Beglarishvili L, Managadze L, Chkhotua A. Influence of type of anesthesia on hemodynamic parameters and outcome of dialysis arteriovenous fistula operations. Georgian Med News. 2015:249:20e7.

14. Armstrong RA, Wilson C, Elliott L, Fielding CA, Rogers CA, Caskey FJ, et al. Regional anaesthesia practice for arteriovenous fistula formation surgery. Anaesthesia. 2020;75(5):626-33.

15. de Jong RH, Robles R, Corbin R. Central actions of lidocaine synaptic transmission. Anesthesiology. 1969;30:19.

16. Solomonson MD, Johnson ME, Ilstrup D. Risk factors in patients having surgery to create an arteriovenous fistula. Anesthesia and Analgesia. 1994;79:694-00.

17. Madison SJ, Alkire MT. Anaesthesia for vascular access surgery. In: Wilson SE, eds. Essentials of vascular access 1st edition. Inchinnan, Scotland, UK.