CORRESPONDENCE

Re. ‘Provision of Vascular Surgery in England in 2012’

Grewal et al. 1 rightly claim the importance of assessing the state of vascular surgery in England at this time of significant change and development of specialty status. However, there are some potentially serious inaccuracies. In the ‘Results’ section the authors say 167 out of 169 Trusts (98.8%) replied, but go on to say that four Trusts did not reply. This appears to be inconsistent.

They also state that only 80 of the 167 Trusts who responded to the Freedom of Information (FOI) requests provide vascular surgery services. Furthermore, the two figures in the article appear to have red flags, presumably representing the hub (Figure 1) and non-hub (Figure 2) vascular providers. Although the text records 48 hub hospitals and 32 non-hub hospitals, the figures seem to represent different numbers of each, although Norfolk and Cornwall are not included in the figures.

The text does not provide a list of Trusts in each category, but some sites are named in the figures, but are indicated as neither hub nor non-hub hospitals. When the FOI request responses for Durham and Darlington NHS Trust, Mid Yorkshire Hospitals NHS Trust (Wakefield), Chesterfield and Derby were reviewed they all said they provide vascular services yet are not clearly represented in the article.

The authors may wish to carefully review the source of their data, available at whatdotheyknow.com because there is a risk that they have misrepresented the responses, making their conclusions about the provision of vascular surgery inaccurate.

REFERENCE


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Re. ‘Re. Provision of Vascular Surgery in England in 2012’

We welcome the comments by Mr Curley regarding our paper on provision of vascular surgery in England in 2012. 1 There is a typographical error and it should indeed state that only two trusts did not reply.

The questionnaire represents a snapshot of vascular services in relation to early 2012. The situation may have changed by now. The aim of the paper was to assess in the most objective way and directly from the Trusts how the centralisation process was developing. The maps were intended as a visual representation of the more detailed tables, especially for readers unfamiliar with English cities.

Addressing the specific trusts mentioned, the data is available in the tables provided within the paper. Royal Derby Hospitals NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust are documented in Table 1 as hub hospitals. Within the West Yorkshire Central County, Mid Yorkshire Hospitals NHS Trust is documented as centralising with Leeds Teaching Hospitals NHS Trust, but continuing to provide arterial surgery at the Mid Yorkshire site. Chesterfield have stated that they are looking to centralise with Derby and as such were not mentioned separately.

REFERENCE


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Re. ‘Cost-effectiveness of Vascular Access for Haemodialysis: Arteriovenous Fistulas Versus Arteriovenous Grafts’

We read with interest the paper of Leermakers et al. 1 We propose that rather than comparing the cost-effectiveness of arteriovenous fistulas (AVF) and arteriovenous grafts (AVG) the real question is: What is the most cost-effective way to provide safe renal replacement therapy (RRT) to patients with end-stage renal disease (ESRD)?

Infection is undoubtedly one of the greatest threats to patient well-being while receiving RRT, and poses a significant cost to healthcare providers.
A retrospective audit was carried out over an 18-month period, comparing bacteraemia rates for each renal replacement modality \((n = 1997)\). Results are expressed as bacteraemia episodes per 1000 patient days and estimated annual costs in brackets (assuming an average cost of line sepsis of £10,000).^2,3^ Haemodialysis (HD) via a central venous catheter (CVC) \((n = 403)\) 1.93 (£33,295.50); HD via an AVF \((n = 670)\) 0.23 (£25,802.50); peritoneal dialysis \((n = 157)\) 0.09 (£19,414.50) and renal transplantation \((n = 1091)\) 0.03 (£22,109.50 in the first year and £5109.50 for each subsequent year). Switching from CVC to AVF \((n = 90)\) reduced the bacteraemia rate from 1.96 to 0.55 \((p = 0.01)\) and to transplant \((n = 38)\) from 2.72 to 0.73 \((p = 0.06)\).

Leermakers et al. report the median life-span of an AVF and AVG to be 28.5 and 25.5 months, respectively, while renal transplantation has a median survival of 13.5 years.\(^1\) These figures support an integrated RRT strategy, including maximisation of opportunities for renal transplantation as a cost-effective means to minimise infection rates in patients with ESRD. In particular, live donor renal transplantation should be considered wherever possible as a means to reduce bacteraemia rates in patients currently dialysing via CVC rather than switching to AVF/AVG, and organ allocation policies based on clinical need (including vascular access status) may be beneficial.

**REFERENCES**


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Re. ‘Re. ‘Cost-effectiveness of Vascular Access for Haemodialysis: Arteriovenous Fistulas Versus Arteriovenous Grafts’

McDermott et al. recognize infections as the most serious and common complication of vascular access (VA) for hemodialysis (HD) or peritoneal dialysis (PD) treatment, with subsequently higher costs for these renal replacement modalities compared with renal transplantation.\(^1\) This may be true for patients with HD through central vein catheters, but certainly not for patients receiving either PD or HD through arteriovenous fistulae (AVF) or arteriovenous grafts (AVG). Several publications have shown similar outcome in terms of morbidity, hospital admission and death as a result of infectious complications in patients on PD or HD with an AVF or AVG as vascular access.\(^2,3^\)

The purpose of our study was to compare all costs necessary to establish and maintain VA through an AVF or AVG. This not only includes costs for treatment of infection, but also in particular costs for access maintenance and revision, like endovascular and/or surgical interventions, to establish long-term patency.\(^4^\)

We do agree that renal transplantation is the ultimate goal to treat young patients, in particular, with chronic renal failure and as in many centers, living-related kidney transplantation is in our center a well-established method for these patient groups. But one should keep in mind that nowadays most patients in HD programs are very old with multiple comorbidities, with a contra indication for renal transplantation. These old patients, who are usually not on the waiting list for transplantation, may certainly benefit from an AVF, which, in addition, incurs lower healthcare costs to main access patency in comparison with the use of AVGs.

Comparing renal transplantation with the outcome of AVF and AVG as HD vascular access, was not the purpose of our study.

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