Journal of Interventional Nephrology

Editor's Note on Chronic Kidney Disease (CKD)

G Vergoulas*

Department of Nephrology, Aristotle University of Thessaloniki, Hippokratio Hospital, Greece

*Author for correspondence:
vergoulas@gmail.com

Optimal medical care of chronic kidney disease (CKD) sufferers requires nephrologists to achieve common diagnostic radiological procedures. For example, renal ultrasounds are often required to consider the etiology of kidney disease and to knock out reversible obstruction. Much more commonly, CKD sufferers require numerous procedures to make certain sufficient everlasting vascular access for dialysis. Some of these processes include preoperative vascular mapping to assess the optimal vessels for construction of arteriovenous fistulas and grafts; surgical construction of fistulas and grafts; placement of Tenckhoff catheters; sonographic and radiological investigation of vascular access dysfunction; thrombectomy of clotted accesses; and surgical revision of accesses due to extreme stenosis, pseudoaneurysms, or infection. In addition, many patients require placement of tunneled dialysis catheters as a "bridge access" till they have a mature fistula or graft. Moreover, these catheters regularly have to be changed due to access malfunction or infection.

In the United States, these methods have been carried out nearly solely with the aid of radiologists, vascular surgeons, and transplant surgeons. These individuals also perform numerous radiological or surgical approaches for different medical services. Moreover, from their perspective, most vascular access procedures requested by nephrologists for their CKD patients are considered elective and of relatively low priority. Thus, for example, a radiologist may additionally be inclined to defer thrombectomy of a graft or placement of a tunneled dialysis catheter for a few days due to the fact of different requests for emergent procedures, reasoning that the affected person can dialyze in the interim with a temporary dialysis catheter. In contrast, the nephrologist recognizes that a functioning vascular access is imperative for continued outpatient dialysis and is loath to subject the patient to unnecessary procedures and the risks of infection associated with temporary access catheters.

The tension between the nephrologist's perspective on vascular access and that of the radiologists and surgeons can lead to frustration, friction, and even acrimony. This has led various nephrologists to pioneer a new model, referred to as "interventional nephrology." Disciples of this new breed have acquired diagnostic and interventional abilities for vascular access techniques generally completed by way of radiologists, however in contrast to the latter, additionally have a unique clinical perspective on the problems of vascular access in dialysis patients.

A progress report in this problem describes the establishment of a complete Diagnostic and Interventional Nephrology Program at the University Miami School of medicine. The authors are to be congratulated on the early success of their developing program and providing a road map that describes the development of this program at their institution. The cause of this commentary is to emphasize areas of communality for other educational programs, to highlight some of the institutional problems that we are dealing with and which form our nearby successes and additionally lack of progress, and to provide a number of guidelines for nephrology education packages that occur from these considerations. The notion that nephrology, as a discipline, should broaden its procedural base has long been discussed. The efforts in nephrology-based diagnostic ultrasonagraphy, has provided

substance to the idea that nephrologists want to take a greater proactive function in the whole provision of nephrologic care of their sufferers as development from stage four to stage 5 CKD.

The "new nephrologist" conveyed a Swiftian sense of irony and frustration with the status quo, however did now not go as a long way as the authentic with regards to the options to the inevitable "turf" battles that occur when nephrologists try to prolong their sphere of clinical expertise and service. Nevertheless, many of our colleagues, mainly in the interventional nephrology camp, have reacted as strongly to these initiatives as if the solution proposed was literally enacted. In both the O'Neill experience and that of the University of Miami, delays in the provision of wanted strategies served as a catalyst in defining a new paradigm in the nearby institutional environment. While delay and inconvenience are essential driving forces for change, the last challenge need to be first-rate of care. In that context, countless effect measures want to be evaluated, inclusive of extend between prognosis and intervention, turnaround time, and profitable outcome. While apparent to the patients, nephrologists, and dialysis middle workforce and administration, any lengthen that interrupts or delays the provision of renal alternative remedy is no longer in the fine pursuits of anyone. Therefore, a large view of the whole get right of entry to manner have to be entertained, as a substitute than a slender focal point on the provision of particular interventions and the accompanying professional fee generation that can result.