
Basilic vein transposition should be the first option

To the Editor,

We have read with great interest the article, entitled 'Long-term patency of autogenous saphenous veins vs. polytetrafluoroethylene

(PTFE) interposition graft for prosthetic hemodialysis access,' published in The Anatolian Journal of Cardiology 2014; 14: 542-6. (1). The authors presented patency rates of saphenous veins and PTFE grafts for hemodialysis access. They obtained the result that an autologous saphenous vein could be chosen as a prosthetic hemodialysis access graft due its higher primary and secondary patency and lower complication rate and cost when compared with PTFE grafts. We congratulate the authors for these valuable results.

In this study, the authors also presented that the basilic vein transposition technique is a challenging surgical procedure, requires a large incision on the arm, and is difficult to do for the patient and surgeon. Basilic vein transpositions have been performed since 1976. There are many techniques for transposing basilic veins to superficially, like minimal invasive surgery, video-assisted surgery, and catheter-assisted surgery. With these techniques, basilic vein transposition can be performed with comfortable conditions for the patient and surgeon and does not require large incisions (2). The only technical challenge for basilic vein transposition is operating for obese individuals and accessing the fistula for hemodialysis. Otherwise, in the text, the authors present that upper arm bridge graft interpositions can be first preferable alternative for hemodialysis access after using the forearm superficial veins. According to the National Kidney Foundation, patients should be considered for transposed basilic vein fistula after using the wrist radiocephalic and elbow brachiocephalic fistulas. If upper arm bridge grafts are used before the basilic vein, performing the basilic vein transposition technique can be impossible or very difficult because of the inefficient mobility of the proximal basilic or axillary vein after occlusion of the bridge graft fistulas (3, 4).

In conclusion, as mentioned in the study, native arteriovenous fistulas have been recommended as a first option, with lower complication rates and costs, for forearm and upper arm fistulas, but we believe that basilic vein transposition is not a challenging technique using minimally invasive techniques, allowing an easy operation. After finishing autogenous forearm fistula chances, the transposed basilic vein should be the first operative technique, as recommended by the National Kidney Foundation, instead of bridge fistula with saphenous or PTFE grafts.

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