North Coast Vascular

"Keep It Circulating" – November 2016 Issue

North Coast Vascular wish you a Merry Christmas and a very Happy New Year. Thank you for your support.

It's hard to believe that another year has passed and we will shortly be entering into 2017. We have had fabulous outcomes for our patients this year and we are always here to assist you in anyway. I will be On-Call over Christmas and New Year. If you require **URGENT** assistance over this period, please do not hesitate to contact me on 0427 282 202.

So once again have a very Merry Christmas, a very Happy New Year and God bless.

Deepak Williams

First Step

by Christine Kemp – NCV Practice Nurse

Non healing wounds can present serious health risks and often require specialised care. Antibiotics and dressings do not cure leg ulcers.

Treatment of underlying problems is the first step in a healing process whose goals are to alleviate pain, speed recovery, regain mobility, and fully heal the wound. Treatment must be directed towards fixing the cause for the ulcer.

Patients with peripheral vascular disease (PVD) often have non healing wounds on their extremities. Decreased blood flow results in poor healing. By treating the underlying vascular problem wounds can be treated effectively and heal much faster.

There are many risk factors that can contribute to the development of non-healing wounds:

- Advanced peripheral artery disease
- Kidney failure
- Venous insufficiency
- Hypertension
- Diabetes
- Lymphoedema
- Inflammatory diseases – vasculitis, lupus or scleroderma
- Smoking
- Inactivity
- Cancer
- infection

How are wounds diagnosed?

There are 3 main types of wounds on the lower extremities: venous stasis ulcers, neurotrophic ulcers, and arterial ulcers. A thorough examination of the wound needs to be completed and other diagnostic testing done to determine any underlying problems that need to be corrected.

Continued over page

North Coast Vascular will be closed from Friday, 23rd December 2016 to Monday, 9th January 2017

What's New at NCV

- Vascular Education Evening at Kingscliff for Doctors and Practice Nurses was well attended and feedback was it was an excellent education evening.
- Dr Deepak educating at UCRH to Students on "The Cold Foot".
- Larger Telehealth presence for Nursing Home Residents in the Northern Rivers.

North Coast Vascular
St Vincent's Private Medical Suites
Suite 2, Level 1,
20 Dalley Street
LISMORE NSW 2480
Ph: 02 6621 2200 or 1300 278 379
Email:
Admin@ncvascular.com.au
Website:
www.ncvascular.com.au

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Haemodialysis Vascular Access

by Chanelle Osborne- Renal Vascular Access Nurse

The provision of adequate haemodialysis is dependent on repeated and reliable access to the central circulation. The radiocephalic Arteriovenous Fistula ("AVF") is the most common fistula as it provides the best option for cannulation.

The AVF is the 'gold standard' for haemodialysis vascular access as it remains the most reliable access due to its history of longer patency rates, less thrombotic events and much less infection rates.

Functioning vascular access is paramount to the adequacy of each haemodialysis session. Establishing a good vascular access starts very early in the spectrum of care of the chronic kidney disease patient, often with education and vein preservation at stage 3 kidney disease and continuing throughout their life.

In patients with kidney disease both arms should be protected anticipating possible use for vascular access, particularly the non-dominant arm. Cannulation and Venepuncture should be avoided. Vascular surgeons should construct an AVF.

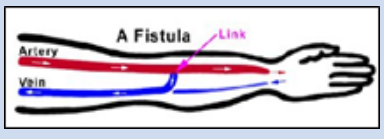
Creation of a Fistula is done to promote a culture of vein preservation in order to maximise the chance of patients with kidney disease to successfully maintain haemodialysis in the future.

Once a fistula has been constructed:

- Bloods are not to be taken from the fistula;
- Cannulas are not be inserted into the fistula arm;
- Blood pressures are not to be taken on the fistula arm;
- Pressure bandages are not to be applied to the fistula arm (unless advised by the vascular surgeon).

Once a fistula is created assessment of the fistula is preformed to detect its functionality.

The thrill (a buzzing feeling created as arterialised blood is shunted into the vein) at the anastomosis is continuous and very prominent. The pulse should be soft and the fistula easy to compress. Assessment by a Vascular Surgeon is done at least every 6 months.



Fistula Anastomosis

Radiocephalic Arteriovenous Fistula

First Step

by Christine Kemp – NCV Practice Nurse (continued)

Treatment Options

Wound care begins with treating any underlying problems contributing to non-healing. This includes treating any vascular problems that could be impeding blood flow to the affected limb. This may be done by ligation of varicose veins, angioplasty +/- stenting, or bypass surgery. Wound care after revascularization includes: Debridement +/- skin graft, compression, topical wound care therapies and antibiotics.

Accurate diagnosis is the foundation of ulcer care.

Vascular Tips - How to reduce the risk of travel related DVT

- Exercise calf and foot muscles regularly.
- Take a break and walk every 1 – 2 hours.
- Keep well hydrated.
- Wear graduated compression knee high stockings.
- High risk people should commence anticoagulant therapy prior to long distance travel.

If you develp a swollen painful calf or breathing difficulties shortly after a journey; seek urgent medical assessment which includes ultrasound scan, anticoagulant therapy AND Grade 3 Compression stockings.