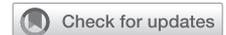


# Interventional Nephrology: What, Who, Why?



### DIALYSIS ACCESS

These 2 words can mean different things from a patient's or a provider's perspective. For the patient, it is a "lifeline" to undergo a life-sustaining treatment, day after day, and lack of an optimal access can literally be a death sentence. Whether be it lack of achieving or maintaining the vascular access.

Dialysis first became available as a support for patients with acute renal failure, during the Korean conflict in the early 1950s, where combat victims who sustained renal failure due to volume loss or crush injuries were able to be supported by temporary dialysis. Until 1960, when the Dr. Belding Scribner created the Scribner shunt, the path for chronic maintenance dialysis became possible. Fast-forward 6 decades, and the United States is now responsible to provide dialysis care to more than half-a-million patients with kidney failure. We still face a daunting challenge and grapple with the reality of an annual mortality rate of 10-20% in these patients. Moreover, although dialysis care affects < 1% of Medicare beneficiaries but consumes more than 9% of direct Medicare costs. Optimal dialysis vascular access is one of the major modifiable factors that influence patient survival, provider satisfaction, and costs of care.

An average patient on hemodialysis receives 150 dialysis treatments each year and has an interaction with a nephrologist on approximately 50 of those visits. Yet, a fragmented model of care is responsible for "our" patients on dialysis to shop for many essential aspects of their routine care (both dialysis related and nondialysis related) to be delivered through multiple institutions, disciplines, or providers. For instance, with regards to dialysis access, current processes of care can lead to long wait times to achieve both an optimal initial dialysis access or delay imminent care to a maintain a dialysis access. The field of interventional nephrology was essentially "home grown," and somewhat altruistic, to fill this gap, and provide a more patient-centric model.

For a provider, the field offers a unique opportunities to examine the biology and science of vascular access, study, improve processes of care, as well as develop procedural

expertise, and push new frontiers of biotechnology to benefit our patients. The field also generates a lot of interest to policy makers, by virtue of the fact that it sits at the important nexus of patient care, resources, and innovation.

The current issue of ACKD journal is dedicated to the history and advances in the field of interventional nephrology.<sup>1</sup> Not only this comes at a critical juncture when our discipline is going thru a major policy transformation but also at a crucial time in terms of career paths in nephrology. The importance of this field touches many aspects of our discipline: the patient care component, training and career choices, improving healthcare costs overall, and enhancing the procedural relevance, among others.

I would like to take the opportunity to congratulate all the authors, and the guest editors, Dr. Oza-Gajera and Dr. Agarwal, for their time commitment and efforts. The issue also celebrates Dr. Anil Agarwal, as the in-coming president of the American Society of Diagnostic and Interventional Nephrology. We hope to provide our readers a comprehensive curriculum through a series of articles that describes the current status of the field and lays out a vision for the future.

Charuhas V. Thakar, MD  
Professor of Medicine  
Division of Nephrology  
University of Cincinnati  
Cincinnati, OH  
Renal Section  
Cincinnati VA Medical Center  
Cincinnati, OH

*Financial Disclosure: The author declares that he has no relevant financial interests.*

### REFERENCE

1. Agarwal AK, Oza-Gajera BP. Dialysis access: the future is already here. *Adv Chron Kid Dis.* 2020;27(3):168-170.