Occulsion of the fistula in a dialysis patient – is it always a common reason?

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摘要

Abstract

A 67-year-old man with chronic glomerulonephritis and end-stage renal disease (ESRD), on maintenance haemodialysis for 1 year, had a history for failure of a right radiocephalic fistula, a right radiocephalic graft, a right subclavian permanent catheter and a left radiocephalic fistula due to refratory thrombosis. He presented to our hospital with intermittent gross haematuria for 9 months and swelling over the right arm and left hand for 1 month. On further questioning, he also reported a history of deep venous thrombosis over bilateral lower legs, 3 months earlier. He had no local cutaneous erythema and heat, fever or flank pain.

His blood pressure was 130/70 mmHg. Physical examination identified pale appearance and swelling over right arm and left hand. On admission, pre-dialytic blood creatinine was 7.2 mg/dL, urea nitrogen 75.4 mg/dL, albumin 3.5 g/dL, haemoglobin 9.0 g/dL, platelet 100 k/μL, cholesterol 68 mg/dL, triglycerate 98 mg/dL, sodium 138 mmol/L, potassium 4.3 mmol/L, calcium 10.0 mg/dL and phosphate 5.1 mg/dL. Pro-thrombin time was 11.6 s (normal 10.7–13 s, control 12.15 s), INR 1.1 and activated partial thromboplastin time 25 s (normal 20–36 s, control 31.1 s). Fibrinogen was 800 mg/dL (200–400), fibrinogen degradation products >20 μg/mL (<10) and D-dimer >1 μg/mL (<0.5). Lupus anticoagulants, anti-thrombin III, protein C, S and other plasma coagulation factors were negative or within normal limits. Urinalysis showed macroscopic haematuria 40–60 per high power field. Prostate sonography (Figure 1) displayed a prostate tumour. Prostate specific antigen (PSA) was 38.94 ng/mL. Transurethral radical prostatectomy was done, and the pathology reported prostate adenocarcinoma without local invasion. Venography for right arm (Figure 2a) and left hand (Figure 3) was performed, for further workup.