Bart Dolmatch, MD

Radiologist Bart Dolmatch, MD, shares the unique aspects of the CiDA meeting and offers advice to those considering adding dialysis access management to their practice.

In October 2008, you and Dr. Ingemar Davidson served as Course Directors for the Fifth Annual Controversies in Dialysis Access (CiDA) meeting in Washington, DC. What is the driving force behind this meeting, and what are its goals each year?

Many different healthcare providers participate in the care of the growing population of patients with end-stage renal disease who require dialysis. Previously, there was no single meeting that brought all of these providers together. In the US, there are different societies that have meetings; the surgeons have the VASA meeting, the nephrologists have the ASDIN, and radiologists have the SIR meeting, but these each tend to bring in physicians who are associated with that particular specialty. Dr. Davidson and I decided a few years ago that this is an area in which many different specialists play a role, and we should try to bring everybody together to discuss the issues and controversies related to dialysis access.

As a first-time attendee in 2008, there were several elements of CiDA that were unique to me. For starters, how would you describe the concept behind Green Talks and Red Talks?

This was the idea of Dr. Davidson, who began our 5th Annual CiDA meeting by acknowledging that many topics of our meeting may be confrontational or even incendiary, resulting in Red Talk. Red Talk is likely to be more emotional than productive. Green Talk approaches conflict in a way that does not alienate or threaten but rather seeks to bring knowledge and understanding to the discussion. We adopted this color labeled way of talking from aviation safety, where it's important to have effective communication up and down a hierarchy. While we considered Red and Green Talk, in fact there are many shades of communication that fall between them.

Having been in the hot seat during the meeting, I know that it's a lot easier to listen to Green Talk and move forward, whereas Red Talk is emotionally charged and distracts from the issues at hand. Although human nature may not allow us to completely escape the anger and confrontation of Red Talk, we wanted the audience and faculty to think about how they would frame their interactions at the outset of the meeting. We wanted to encourage everyone to play nicely, although not everyone did. That's one reason why CiDA is such a stimulating meeting—the unpredictability of human interaction.

Based on the demographics of the meeting's attendance and your experiences collaborating with other physicians, what are you learning about the specialties who are currently treating dialysis access patients?

It is fascinating to see who attends a meeting such as CiDA. We invite everyone, whether they are surgeons, nephrologists, radiologists, nurses, physician extenders, technologists, technicians, or anyone who cares about dialysis access. What we've seen is that the meeting's attendance mirrors the larger population of providers who are involved in providing dialysis access care. Three quarters of the attendees are physicians, and about 15% to 20% are nurses, technologists, physician assistants, nurse practitioners, and technicians. Regarding physician participants, we have nearly equal proportions of the three primary specialties; surgery, nephrology, and interventional radiology, although surgeons are a bit more represented. I would have thought we'd have a few more nephrologists and somewhat fewer surgeons, because the nephrologists are really on the upswing of learning interventional techniques. But both groups are clearly interested in dialysis access, as are the interventional radiologists.

How would you describe the effect that endovascular techniques have had in treating dialysis access patients?

Plain old balloon angioplasty has been one corner-

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stone of maintaining hemodialysis access for many years, and it continues to be a very important technique. Unfortunately, we've learned that the durability of angioplasty in maintaining dialysis access is not as good as patency results we've seen in other vascular territories. New platforms such as covered stents hold promise, and we will continue to study other options, possibly including drug-eluting therapies and hybrid surgical/catheter methods of providing dialysis access.

What is the biggest challenge in maintaining dialysis access in chronic patients?

The biggest challenge we all face is determining the appropriateness of various therapies. Appropriateness manifests in two different ways. First—on the single visit—what is the best treatment for a particular patient's problem? In the CiDA meeting, we present cases and discuss whether a surgical or interventional technique would be preferred—or perhaps doing nothing at all. We honestly don't have the answer in many instances. There are also many questions regarding appropriateness of therapy during repeat visits—how many times can we do something to a patient's dialysis access before we try something else or abandon it and refer the patient for a new access or some definitive treatment beyond what we have been doing all along? When enough is enough? Our uncertainness is sometimes related to a specific patient's circumstance. A young patient with other dialysis access possibilities may need to be treated differently from a very old patient who is on his very last access (where access preservation may be crucial). The decisions we face are complex and are based not only on cost, safety, and efficacy, but also on the specific patient's situation. All of this is controversial and therefore grist for the CiDA mill.

What advice would you offer a physician who is considering adding dialysis access management to his practice?

They must first understand the broad overview of end-stage renal disease, paying particular attention to the complexity of this group of patients and the different forms of renal replacement—hemodialysis, peritoneal dialysis, and transplant. It's also important to understand the current national trends regarding various options for dialysis access as well as access management and treatment outcomes. Once you start to understand dialysis from a patient's perspective and the healthcare system's perspective, you gain a much better feeling for what you can do to help this patient population. I think many people look at dialysis access maintenance as merely mastering another subset of techniques but that misses the much larger point.

Physicians who want to broaden their understanding have many educational opportunities, but CiDA remains the one meeting where physicians can get a better understanding of contemporary practice, as well as the controversies and uncertainties inherent in managing the dialysis patient population as seen by the broad access community.

What can you tell us about CiDA 2009?

This year's meeting will be held in San Francisco in mid-November, most likely on Thursday and Friday, November 12 and 13. We'll lock down the exact dates and venue between now and the time this interview is published. The format will continue to be a full 2-day meeting, featuring a faculty composed of near-equal numbers of interventional radiologists, clinical and interventional nephrologists, and vascular/endovascular surgeons. We'll continue with our innovative format that brings out controversy and opens new frontiers. For example, we'll have a session on dialysis access simulation training. It's similar to what the airlines have done to improve safety, emphasizing communication skills, knowledge, and simulation. The experience is like a flight simulator, but of course the physician survives a "crash."

The overall format will remain the same as in past years, where about a third of the meeting will be debates, a third will be case presentations to a panel of experts, and a third will be didactic presentations. Last year, we invited attendees to present a case during the general session, and it was so interesting that we plan to do it again. Anyone who wants more information about CiDA may want to visit the CiDA Web site at www.ccm-cme.com/dialysis. ■

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