AN INTERVIEW WITH...

Haimanot (Monnie) Wasse, MD, MPH, FASN, FASDIN

Dr. Wasse discusses her work as President of the American Society of Diagnostic and Interventional Nephrology, her social media presence, and hot topics in vascular access, including global differences in use and harmonization in outcome measures.

Congratulations on completing your 2-year term as the first female President of the American Society of Diagnostic and Interventional Nephrology (ASDIN)! Under your leadership, the society published its first guideline publications since 2007—one on hemodialysis access–induced distal ischemia and another on percutaneous AVFs.[1,2] What was that process like, and why was it important to you that ASDIN publish white papers on these topics?

Shortly after becoming ASDIN President, I wrote out several goals that I wanted to accomplish during my tenure to both benefit our members and broader community and maintain the relevance of the society. We solicited the society for key topics, identified a lead writer, formed small multidisciplinary workgroups, and set deadlines. At the time, endovascular arteriovenous fistula (AVF) devices had just received FDA approval, and yet there was limited information on patient selection, dialysis staff education, and cannulation, so that topic was particularly ripe for the choosing. After review of the literature, it was clear that the evidence supported crafting a white paper that was intended to help readers make a clinical decision and convey society recommendations, rather than a position paper or clinical practice guideline. I'm happy to have accomplished my goal of publishing these white papers in our society-affiliated journal, *Journal of Vascular Access*. Although COVID-19 activities delayed us, the third paper we'd planned to complete before my term-end on the management of cephalic arch stenosis is in the submission phase, so look for that soon.

In your keynote Henry lecture at this year's meeting of the Vascular Access Society of the Americas, you spoke about harmonization in vascular access standards and the lack of consensus on trial endpoints, an issue you've also studied in several published works. Could you summarize why this is such a complex area and what can be done to tackle the issue?

With so many well-established, evidence-based care algorithms in the management of cardiac ischemia or stroke, one has to ask why there aren't evidence-based treatment pathways for dialysis access, such as when a patient presents to the emergency room with a thrombosed arteriovenous (AV) access. Should anticoagulation be continued? What is the optimal timing for successful thrombectomy that promotes improved long-term patency? What is the most efficacious and cost-saving approach to thrombectomy? When is enduring patency unlikely and it's time to say "no" to the fifth thrombectomy procedure in 4 weeks and call for surgical revision? We certainly have enough patients and events to address these questions. What makes dialysis access particularly complex, and in some ways impedes progress in this area, is that there is a general lack of consensus among specialties on key outcomes because so many types of practitioners are involved with dialysis access care.

During the Henry lecture, I showed a somewhat tongue-in-cheek slide of a nurse, nephrologist, surgeon, and interventionalist all gathered around the patient, each asking different questions from their own perspective about the access. Can I cannulate it? Can the patient dialyze? Is it clotted? Is there postpercutaneous transluminal angioplasty residual stenosis? Will cannulation hurt? These questions describe the wide variety of outcome measures for the same procedure, such as AV access creation. In fact, recent randomized studies support this notion, with wide variation in both primary study outcomes (ie, unassisted clinical AVF maturation vs physiologic AVF maturation) and outcome definitions. Without a common lexicon, comparative assessment of study outcomes across trials

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cannot be done to guide evidence-based clinical practice. A way to address this is to adopt a core panel of trial definitions and outcome measures that are evaluated and reported in all clinical trials when examining a certain intervention or device. These vascular access trial definitions already exist for both AV access and central venous catheter clinical trials, and they were developed by a multidisciplinary vascular access work group of stakeholders, which I codirected as part of the Kidney Health Initiative that is sponsored by the American Society of Nephrology and the FDA.

You and colleagues recently looked at data from DOPPS (Dialysis Outcomes and Practice Patterns Study) to evaluate global differences in vascular access use.[3] What were your biggest takeaways, and was there anything learned from this that could benefit from future study?

These studies demonstrated large international differences in AV access location, successful use, and time to use. Notably, patients in Japan have significantly greater AVF maturation and much earlier use than other countries, which may be attributed to lower dialysis machine flow rates (200 mL/min vs 400-500 mL/min in the United States), use of smaller-gauge needles, and more forearm AVFs. The shift in the United States from lower to upper arm AV access indicates the importance and need for establishment of an access life plan, as recommended by the 2019 Kidney Disease Outcomes Quality Initiative clinical practice guidelines for vascular access,[4] and may warrant studying the impact of initiatives like the Save Your Vein campaign on surgical outcomes and broader use of surgical techniques associated with improved AVF outcomes (eg, the RADAR [radial artery deviation and reimplantation] technique).

There have been many studies looking at predictors of vascular access dysfunction that have turned out to not be true predictors. What do we know for certain about predictors of failure, and are there any particular areas of possible investigation that seem fruitful?

There are several predictors of AV maturation failure, such as sex, race, and diabetes, but a key modifiable predictor of AVF success is surgeon selection. Surgeon practice patterns predict AV access placement type, and surgical training predicts AVF success. The risk of primary AVF failure is significantly lower among surgeons who perform ≥ 25 AVFs during training.[5] Therefore, the training period is really important, considering that Centers for Medicare & Medicaid Services data indicate that the majority of surgeons in the United States who perform AV access create < 30 per year.

Your role as an interventional nephrologist is a very personal one: individualizing the best vascular access option for every patient. How would you describe your philosophy for patient care?

My philosophy for patient care is that there is always a solution. This means that through a multidisciplinary approach to complex patient issues, it is possible to find the best path forward—regardless of the specialty. It is the patient's outcome that matters, and this should drive the collaborative spirit that we need to see more of in the field of vascular access.

The Centers for Disease Control and Prevention has identified that chronic kidney disease (CKD) is more common in the Black and Hispanic populations than in non-Hispanic white or Asian populations.[6] What do you think should be done to address this disparity?

A great deal of work has been done in this area, but I would say we need earlier kidney disease recognition and management of comorbid conditions, and patients require a greater understanding of progression and what eventual kidney failure constitutes. In addition, barriers to care need to be eliminated to halt CKD progression, and we need a more equitable route to renal transplantation.

What do you consider to be the highest-priority unmet needs in vascular access research?

I can think of a few. Little is known about the optimal dialysis access blood flow range that avoids straining or exacerbating an individual's cardiopulmonary status while still achieving their dialysis adequacy needs. Also, we need more research into the prevention and effective treatment of progressive central venous stenosis, outside of catheter avoidance.

You are often seen on Twitter (@wasse_m) sharing complex case images and asking fellow physicians how they would manage it, but there are also some day-in-the-life moments. What are your goals with your social media presence?

A little of everything: teaching, sharing things I care about (like health disparities and politics), and linking with a broader community of those inside and outside my field. Honestly, practically everything I learned about COVID-19 in the past 8 months was first posted on social

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media, so the platform can be really useful for getting the word out about new approaches and research findings. My GIF game still needs some work though! ■

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