For our (referring) nephrologists we have established certain minimal requirements that have helped with access initiation (evaluation by IN physician or in joint clinic):

a. Every access has to be evaluated a few days prior to first use with needles, apply map, last minutes fixes, etc.
b. At that time set parameters for interventions based on the exam (when/if to ligate that extra sidebranch, lipectomy, [re-]angioplasty inflow etc.)
c. Every access has to be evaluated 3-4 months after initiation to ensure that "one-site-itis" does not manifest but that all of the access is used
d. Further f/u specific to access and HD unit (some need more help than others)

Current patterns of care that have been successful in shepherding accesses along look somewhat like this:

a. Wound check/suture/staples removal 2-3 weeks post-surgery
b. Evaluation for sidebranches/early stenosis at 6-8 weeks; extra time is given to "snuff-box" and elderly patients
c. Physical exam ~ 10 days after side-branch ligation (on occasion access occludes or stenosis develops rapidly)
d. Angioplasties of outflow then inflow with eye on maximizing flow with balanced inflow-outflow for "low" intra-access pressures
e. Access map at around 3-4 months, often 6 months for "snuff-box" and elderly (grab bag for slow maturation)
f. If access transitions to use, follow-up is determined by clinical performance and typical f/u patterns for issues treated during maturation period (juxta-anastomotic 6-18 months, cephalic arch 3-4 m, after cephalic arch stent graft 6 m, 9-12m if on Plavix/Coumadin and demonstrated longer patency)
g. For pre-ESRD: Access that has reached "maturation" by physical exam, if with angioplasty interventions first 3-4 months later, then q6 x 2, then q12 months, reset if intervention; if without interventions, then q 6 months x2, then q12 months, if intervention use pattern e-1 (3-4, q6x2,q12)

And if anything looks questionable, introduce earlier physical exams.

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