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Editorial Comment / Editoryal Yorum

First but not last: Forearm!

İlk ama son değil: Önkol!

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Improved survival and higher diabetes rates in patients with end-stage renal disease have rendered vascular access an increasingly challenging issue. Autogenous conduits are recommended by the current guidelines for vascular access over other options.[1] In case of failing radiocephalic or brachiocephalic arteriovenous fistulas, humeral basilic vein transposition should be preferred over arteriovenous grafts. To preserve the proximal vasculature, assessment of forearm basilic vein transposition may reveal a promising option for arteriovenous fistulas.

I would like to congratulate the authors for their efforts on autogenous vascular access. Unfortunately, studies on basilic vein transposition in the forearm are very limited and mostly comprise of case series with a small number of patients. As mentioned by the authors, the retrospective design, lack of a control group, and small smaple size are the main limitations of this study.[2] In contrast to other series published, in cases where the basilic vein was too short, the authors used an extension with the saphenous vein. However, there would be a risk for a puncture to disrupt the sapheno-basilic anastomosis which poses a risk for catastrophic bleeding and loss of venous access, as the sapheno-basilic anastomosis would be on the fistula trace for puncture for dialysis access. Therefore, a forearm loop graft with *in situ* basilic vein may be a more preferable option for short forearm basilic veins.

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