

Oral presentation

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A survey of people with ventriculoatrial shunts in the community

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Background

Though most shunts originally used in UK were ventriculoatrial (VA), they are now rarely used and the ventriculoperitoneal (VP) route is preferred. Stated reasons include that VA shunts require more revisions, that they are more prone to infection, and that such infections are likely to lead to septicaemia and nephritis. Adult shunted patients are often discharged from follow-up and do not see a neurosurgeon thereafter, and those seen because of problems might present a skewed picture of the whole. We therefore decided to survey people with VA shunts in the community to determine whether they still had their VA shunt and whether they had had problems with it.

Materials and methods

A request for assistance was published in LINK, ASBAH's quarterly journal. This was followed by the mailing of a questionnaire to all those on ASBAH's database recorded as having a VA shunt. The questionnaire asked only 5 questions, to maximise response rate: 1) Do you have a VA shunt? 2) If so, for how long have you had it? 3) Have you ever had a VA shunt? 4) If so, how long did it last? 5) Have you ever had problems with your VA shunt such as blockage or infection? (if "yes" please say what they were). The responses were then collated.

Results

Of 405 VA-shunted people on the database, 11 had been incorrectly entered and 5 had died. 157 responded. Six were excluded (one had a Torkildsen shunt and in 5 the data were not analysable). One hundred and eleven peo-

ple still had their VA shunt, and 38 no longer had it; 37 of these had been converted to VP (4 retaining their VA shunt). One no longer had a shunt. In those who still had one, it had been in place for a mean of 30.8 yrs (0.3–44 yrs), while in those who no longer had one, it had been in place for a mean of 12.3 yrs (0.12–43 yrs) before removal. Fifty-six people (38%) reported no problems with their VA shunt. Of the remainder, obstruction occurred in 48% of those still with a VA shunt, and in 79% of those who no longer did, these involving the VA shunt. Infection was reported in 12.75%, with one certain and one doubtful case of nephritis. Two reported thrombus formation but there were no reports of pulmonary hypertension in this series. There were 3 cases of catheter migration, one to the lung and two to the heart. Thirteen had converted from VP to VA, 2 for infection, 4 for obstruction, 3 because of elective abdominal surgery and one because of CSF malabsorption.

Conclusion

VA shunts appear to perform better and for longer than current opinion suggests.