การวางแผนดูแลรักษาตนเองล่วงหน้าในผู้ป่วยโรคไตเรื้อรัง

Making Advance Care Plan in Patients with Chronic Kidney Disease

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Potential Conflict of Interest: None

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Two Hardest Questions

Am I doing the best for my patient?

Will my patient benefit from renal replacement therapy?

Am I doing the best for my patient?

Patient-Physician Relationship

Paternalistic

- Passive role for patient
- Works well when patients have limited information and an acute condition

Informative

- Professional provides information and patient makes decision independently
- Information may be derived from outsources

Shared Decision

- Patient, relatives and professional work together
- Collaboration on options, goals and results
- Works well when patient has long-term, chronic condition

Comprehensive Conservative Care

KDIGO Guideline: 2012

STRUCTURE AND PROCESS OF COMPREHENSIVE CONSERVATIVE CARE MANAGEMENT (Not Graded)

- **CCC should be an option in people who choose not to pursue RRT and this should be supported by a comprehensive management program. All CKD programs and care providers should be able to deliver advance care planning ...**
- **Coordinated end-of-life care should be available to people and families through either primary care or specialist care ...**
- **The comprehensive management program should include protocols for symptom & pain management, psychological care, spiritual care, and culturally sensitive care … , followed by the provision of culturally appropriate bereavement support.**

CCC does not include dialysis!

Comprehensive Conservative Care

Holistic patient–centered care plan for high-risk CKD patients:

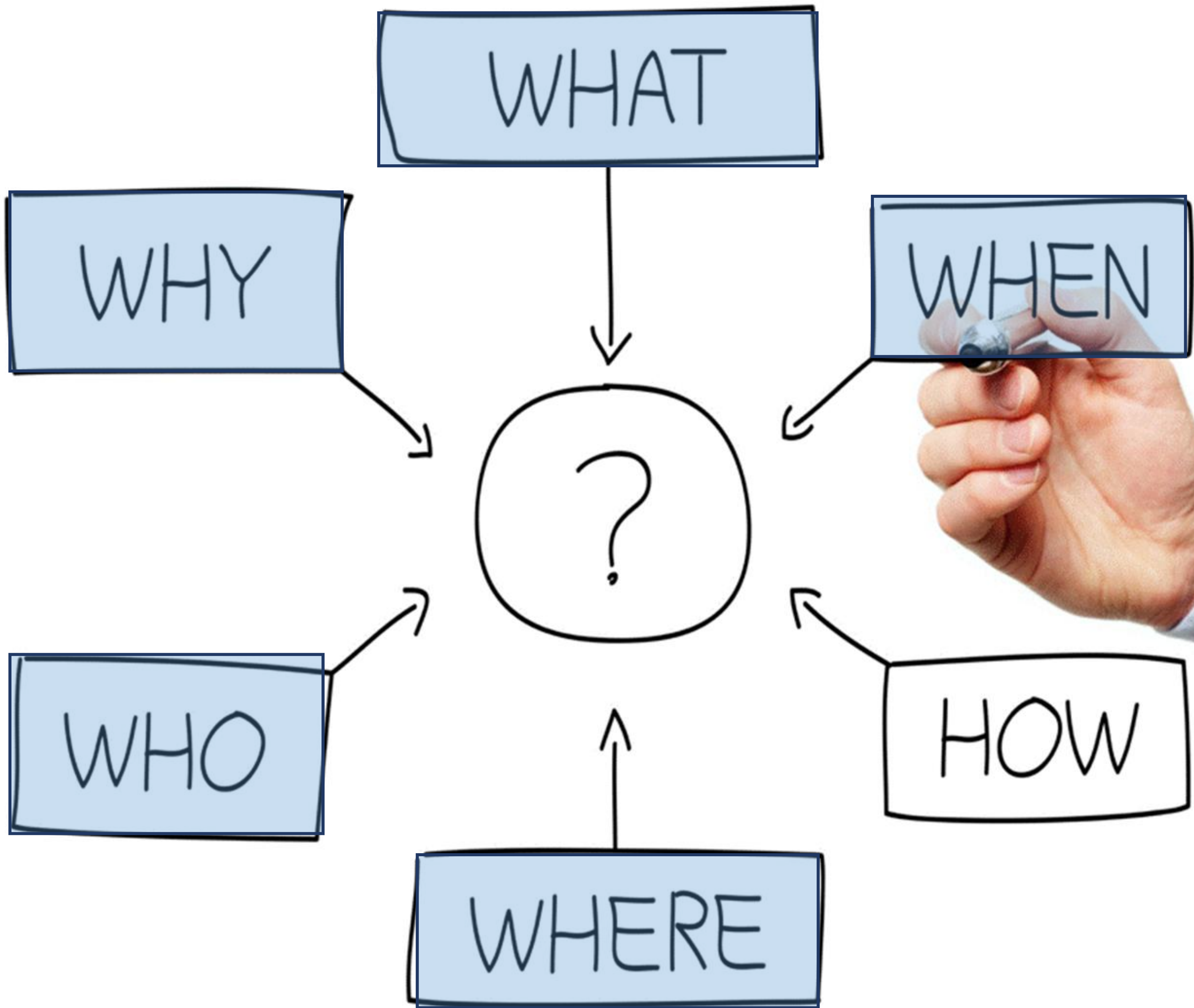
- Interventions to delay progression of kidney disease and minimize risk of adverse events or complications
- Shared decision making
- Active symptom management
- Detailed communication, including advance care planning
- Physiological and psychological support
- Social and family support
- Cultural and spiritual domains of care

Modified from Kidney Int 2015;88: 447-59

Case 1

A 79 year old woman

- Type II Diabetes Mellitus > 10 years, HT, Single vessel disease S/P PTCA
- Worsening renal function over 9 months
- During Pre-Dialysis Discussions
    - Patient is ambivalent about commencing dialysis
    - Her two daughters strongly encourage dialysis
    - Her son is ambivalent


WHAT
WHY
WHEN
?
WHO
HOW
WHERE

Advanced Care Planning is a Shared Decision Making Process

สร้างความพร้อม

1

Seek your patient's participation.

แจ้งให้ทราบถึงทางเลือกในการรักษา

2

Help your patient explore & compare treatment options

ร่วมประเมินทางเลือก

3

Assess your patient's values & preferences

ตัดสินใจ / แก้ไขข้อขัดแย้ง

4

Reach a decision with your patient.

5

Evaluate your patient's decision.

ติดตามประเมินผลของการตัดสินใจ

Patient

Family

Physician
Nephrologist

http://touchcalc.com/calculators/sq

HD MORTALITY PREDICTOR

SERUM ALBUMIN

3.5 g/dL

SURPRISE QUESTION

(•) I would NOT be surprised if my patient died in the next 6 months.

( ) I would be surprised if my patient died in the next 6 months.

AGE 79 years

DEMENTIA

( ) My patient HAS dementia.

(•) My patient does NOT have dementia.

PERIPHERAL VASCULAR DISEASE

(•) My patient HAS peripheral vascular disease.

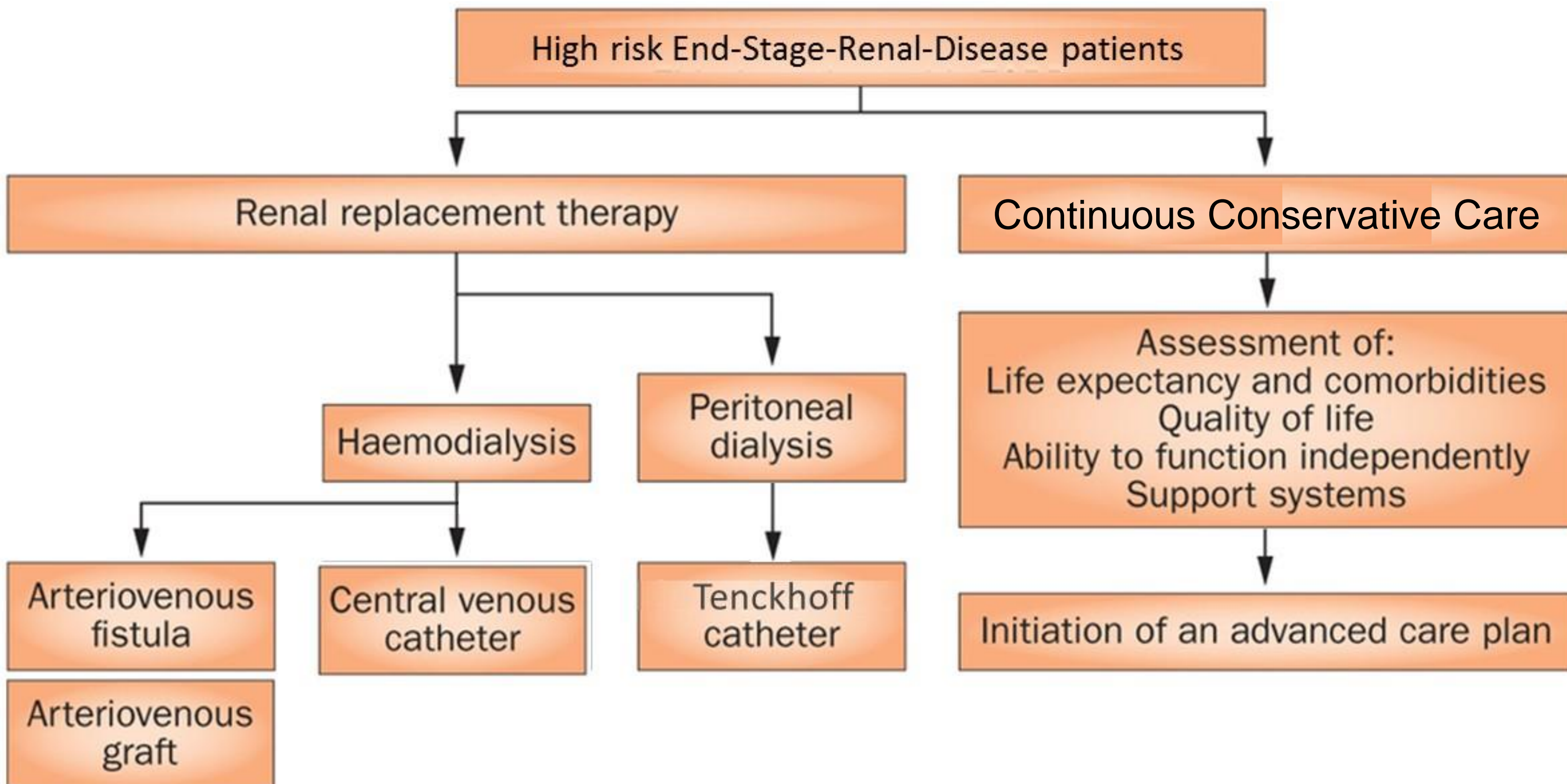
( ) My patient does NOT have peripheral vascular disease.

XBETA: -48.56

Predicted Six Month Survival: 71%
Predicted Twelve Month Survival: 43%
Predicted Eighteen Month Survival: 23%

Cohen LM, et al. Predicting Six-Month Mortality for Patients who are on Maintenance Hemodialysis. *Clin J Am Soc Nephrol 2010;5:72-9*

for High Risk ESRD Patients



Modified from Nature Reviews Nephrology 2014: 10:116-22

Will my patient benefit from renal replacement therapy?

1. Life expectancy decreased as age and time on dialysis increased, with a rapid fall in 5-year survival in patients over the age of 65 years (14.5%)

2. Severity of co-morbid conditions and functional capacity are *more important* than age in predicting survival and morbidity

3. No survival advantage in receiving RRT for those who were older than 75 years or with WHO performance score ≥ 3

Hemodialysis Current Practice Recommendation Thailand 2014

http://www.nephrothai.org/news/news.asp?type=KNOWLEDGE&news_id=417

ผู้ป่วยสูงอายุมากกว่า 75 ปี และมีสิ่งตรวจพบอย่างน้อย 2 ใน 4 ข้อ ได้แก่

1) แพทย์ผู้รักษาเห็นว่าผู้ป่วยมีโอกาสสูงที่จะมีชีวิตอยู่ได้ < 1 ปี
2) มี comorbidity สูง
   (เช่น Charleson comorbidity score > 8 หรือ
   FREIN 6-month Prognosis Clinical Score > 9)
3) ความสามารถในการประกอบกิจวัตรประจำวัน และการทำงาน
   (functional status) ต่ำมาก
4) มีภาวะทุพโภชนาการรุนแรง

Identify Rx Goals for ESRD Patients

Based on their overall condition and preferences:

1. **Aggressive therapy with dialysis w/o limitations on other treatments**
2. **Dialysis but with limitation on aggressive procedures e.g. CPR, intubation, mechanical ventilation, thus to balance life prolongation & comfort**
3. **Patients who decline dialysis and prefer active medical management with the primary goal of care to be comfort**

Decision to Not Initiate or to Discontinue Dialysis, If Appropriate

PATIENT SAYS "NO" DIRECTLY	• Patients with decision-making capacity, who being fully informed and making voluntary choices, refuse dialysis or request that dialysis be discontinued
PATIENT SAYS "NO" INDIRECTLY	• Patients who no longer possess decision-making capacity who have previously indicated refusal of dialysis in an oral or written advance directive
PROXY SAYS "NO"	• Patients who no longer possess decision-making capacity and whose properly appointed legal agents/surrogates refuse dialysis or request that it be discontinued
PROVIDERS SAY "NO"	• Patients with irreversible, profound neurological impairment such that they lack signs of thought, sensation, purposeful behavior, and awareness of self and environment.[1,2]

[1] J Am Soc Nephrol 1994;4(11):1879-83.
[2] N Engl J Med 1990;322(14):1012-5.

Advanced Care Plan

- A process that incorporates the principles of **patient-centered care, shared decision making about risk-benefit of the therapy, self-management and autonomy** to support individuals to make plans for their future care
- The process is **reflective** in nature, founded on personal beliefs, values, goals and preferences in life
- Throughout this introspection the person identifies **what is matter**, and how this translates to **clinical decision-making preferences** in the event that they are unable to communicate decisions related to medical care independently (**proxy**)
- The renal care team should attempt to obtain **written advance directives** from all dialysis patients

การวางแผนดูแลรักษาตนเองล่วงหน้า

๑. **Patient preference** คือ สิ่งที่ผู้ป่วยต้องการหรือให้ความสำคัญ (ตัวอย่างเช่น อยากใช้ชีวิตอย่างไรในแต่ละช่วง อยากพบ-คุยกับใคร อยากทำอะไรที่ยังไม่ได้ทำหรืออยากให้ใครทำอะไรให้ เป็นต้น) รวมถึงเป้าหมายการดูแลรักษาเมื่อถึงเวลา ซึ่งต้องเกิดจากการที่ผู้ป่วยรับรู้แล้วว่า ตนเองเป็นโรคไตเรื้อรังถึงขั้นไหนแล้ว การรักษาจะได้ผลเป็นอย่างไร

๒. **Advance decisions** คือ การแสดงเจตนาว่าจะรับ/ไม่รับการดูแลรักษาเมื่อถึงเวลา หรือเมื่อผู้ป่วยไม่อยู่ในภาวะที่สามารถตัดสินใจได้ด้วยตนเอง คือการปฏิบัติในส่วนที่กฎกระทรวงมาตรา ๑๒ แห่ง พรบ.สุขภาพแห่งชาติ พ.ศ.๒๕๕๐ รองรับ

๓. **Proxy nomination** คือ การเลือก “บุคคลใกล้ชิด” ผู้ทำหน้าที่แสดงเจตนาแทน เมื่อไม่สามารถตัดสินใจได้ด้วยตนเอง

Resolving Conflicts about Dialysis Decisions

Create a Calm Environment

Open Yourself to Understanding

Need a Non-Judgmental Approach

Focus on the Issue

Look For Solutions

Implement Agreement

Continue to Communicate

Take Another Look

Resolving Conflicts about Dialysis Decisions: Options

- **Establish a systematic due process approach for conflict resolution if there is disagreement about what decision for dialysis initiation.** The sources of conflict may include:
  1) miscommunication or misunderstanding about prognosis;
  2) intrapersonal or interpersonal issues; or
  3) special values

Questions to Resolve the Conflicts about Dialysis Decisions

- Why does the patient or family member desire or not desire for dialysis initiation?
- Does the patient or family member understand the diagnosis, prognosis, and treatment alternatives of dialysis?
- Is the refusal consistent with the patient's values and goals?
- Does the physician understand the psychosocial, cultural, or spiritual concerns and values the patient or family member has?
- Should we consult other personnel for assistance in fully understanding the concerns of the patient or family member?
- Have strategies in the Decreasing Provider Patient Conflict project been used as appropriate?

Resolving Conflicts about Dialysis Decisions: Options

- **Establish a systematic due process approach for conflict resolution if there is disagreement about what decision for dialysis initiation.** The sources of conflict may include:
  1) miscommunication or misunderstanding about prognosis;
  2) intrapersonal or interpersonal issues; or
  3) special values
- **Consider a time-limited trial of dialysis for patients requiring dialysis, but who have an uncertain prognosis, or for whom a consensus cannot be reached about providing dialysis.**

  In this way, time limited trials may promote informed shared decision-making.

Evaluation of Treatment Decisions

- ไม่ใช่การทำครั้งเดียวแล้วจบ แต่สามารถเปลี่ยนแปลงได้เสมอ ขึ้นกับสถานการณ์
- ต้องติดตาม และมีการพูดคุยกับผู้ป่วยและญาติเป็นระยะ
- ต้องอาศัยทักษะการสื่อสารที่มีประสิทธิภาพ / Trust

Case 1

A 79 year old woman

- Type II Diabetes Mellitus > 10 years, HT, Single vessel disease S/P PTCA
- Worsening renal function over 9 months
- Controversy in dialysis decisions
- Next Steps
    - Evaluate patient's comorbidity score, prognosis clinical score, and performance status
    - Well informed for all treatment alternatives
    - Explore personal concerns, beliefs, values and goals

To cure sometimes, to relieve often, and to comfort always — this is our work. This is the first and great commandment. And the second is like it.

Thou shalt treat thy patient as thou wouldst thyself be treated.

Thank you for your attention

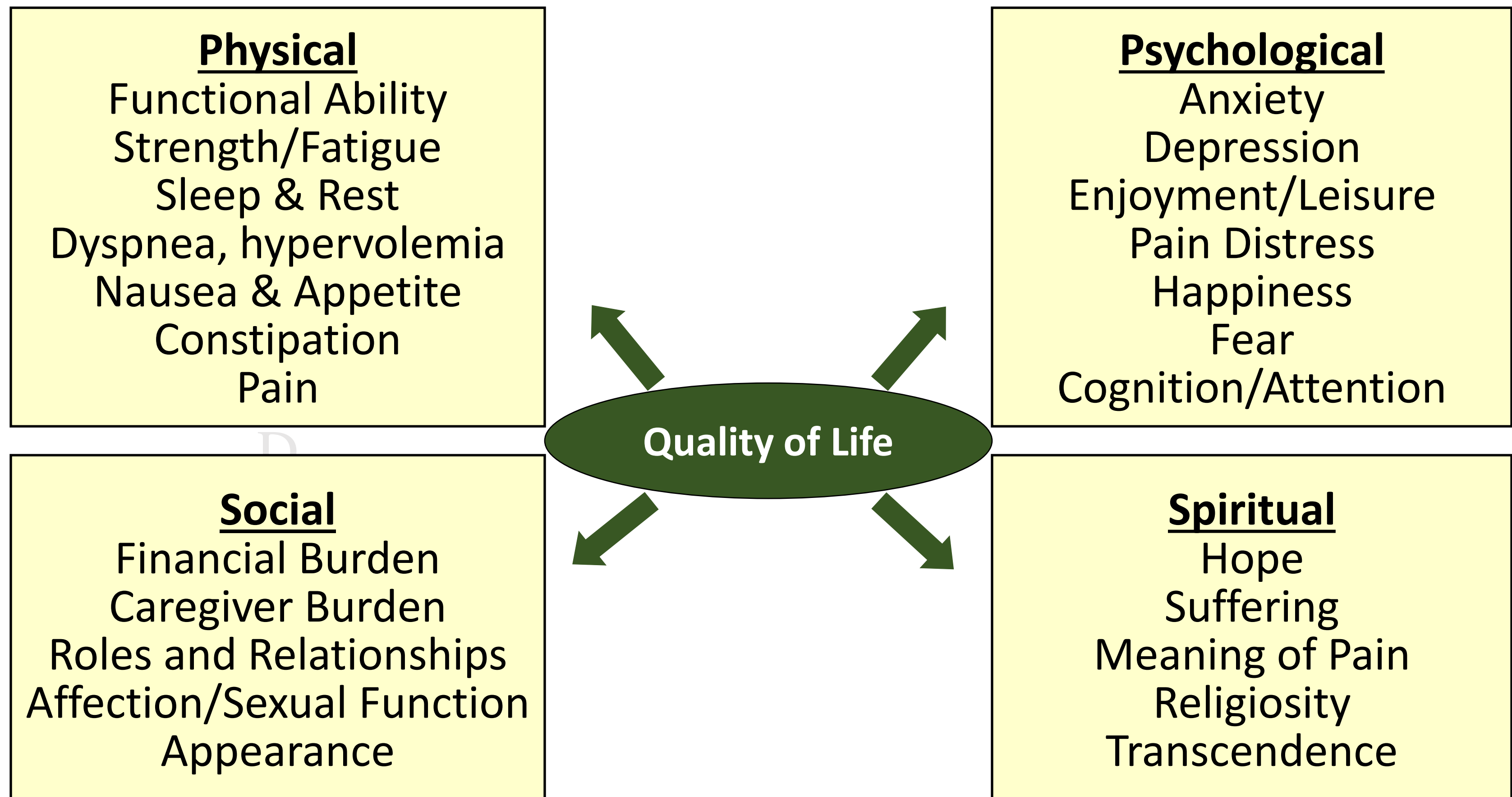
Case 2

A 75 y old man, blindness from diabetic retinopathy, gouty arthritis, chronic AF,
deteriorate renal function now requires RRT.

- Patient refused dialysis.
- Six months later he was admitted with dyspnea from fluid overload.
- He was intubated and put on ventilator.
- Now all her children request dialysis.
- The patient rely on her children to make decision.

Providing Effective Palliative Care

- It is not only survival that is important but crucially, the symptoms, quality of life, and experience of illness on the palliative care/conservative management pathway



Recommended

Acetaminophen: Maximum daily dose of 3.2 g/day. In high risk patients limit the maximal dose to 2.6 g/day (chronic stable liver disease, alcoholics, and malnourished patients).

Hydromorphone: Hydromorphome-3-glucuronide (a toxic metabolite) accumulates without dialysis therefore this may not be an appropriate analgesic for patients with stage 5 CKD NOT on dialysis. Long acting Hydromorphone is relatively contraindicated in ESRD based on expert opinion, due to the narrow therapeutic window for opioid analgesic effect relative to toxicity.

Fentanyl Patch: Should not be started in opioid naïve patients

Methadone: Monitor QT by ECG.

Gabapentin: Titrate slowly; doses up to 600 mg/day are generally safe but monitor for side effects, especially with doses above 300 mg/day (nystagmus, ataxia, tremor, somnolence, and reduced level of consciousness).

Use With Caution

Oxycodone: Limited evidence of pharmacokinetic safety in CKD. Literature reports suggest no major concerns; has a higher potential for abuse than the above-recommended opioids.

Tramadol: Sustained release tablets NOT recommended in dialysis patients. Seizure with doses higher than 150mg daily in eGFR < 30 ml/min a concern.

Nortriptyline/desipramine: Tricyclic antidepressants are alternatives to gabapentin although with higher risk for adverse effects.

DO NOT USE Codeine, morphine, meperidine, propoxyphene

Morphine, codeine, meperidine, propoxyphene have neurotoxic metabolites that are renally excreted and that accumulate in chronic kidney disease with a high likelihood of toxicity.

Dyspnea

- In prospective studies approaches 80% in final days
- Effectively controlled in < 50% in studies
- Multifactorial, Pneumonia is a common final event

- Non-Pharmacological

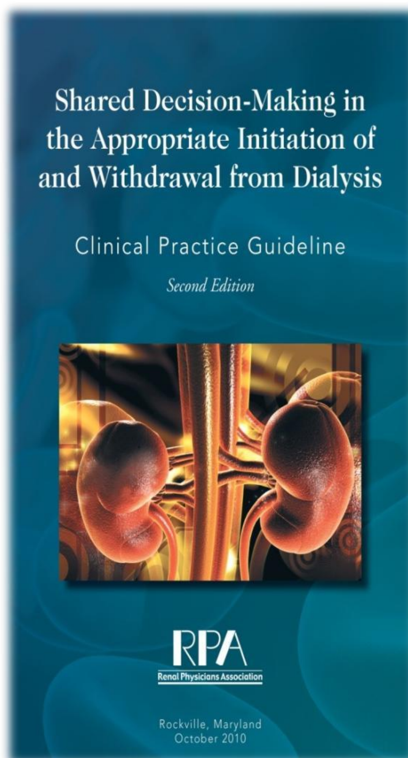
Calm reassurance	Fan
Open window	Sitting upright

- Pharmacological

Oxygen	Diuretics
Opioids, Sedatives	Anti-secretory agents

Suggested Reading

- RPA guideline on initiation and withdrawal of dialysis www.renalmd.org/WorkArea/DownloadAsset.aspx?id=2787



- Five policies to promote palliative care for patients with ESRD.
  Clin J Am Soc Nephrol 2013; 8:1783-90.
- A palliative approach to dialysis care: a patient-centered transition to the end of life.
  Clin J Am Soc Nephrol 2014; 9:2203-9.
- Supportive care: comprehensive conservative care in end-stage kidney disease.
  Clin J Am Soc Nephrol 2016; 11:1909-14.

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