Decision-making around commencing dialysis

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Mr. H was an 86-year-old man with diabetic and ischemic nephropathy, otherwise well.

He was followed in a CKD Clinic for several years, with slowly worsening kidney function.

He was provided with detailed information about dialysis and nondialysis options, and these were discussed with him periodically, but he was extremely anxious about these discussions and could not make a choice.
Mr. H

At eGFR 9 ml/min/1.73 m², he developed symptoms of volume overload and decided to have peritoneal dialysis (PD).

He was admitted to the Nephrology service to get a PD tube placed rapidly, but his dyspnea worsened and he required urgent hemodialysis.

He developed chest pain on his first run of hemodialysis, was diagnosed with a myocardial infarction and died a week later in the ICU.
Timely initiation of dialysis

**eGFR <6 ml/min/1.73 m²** without reversible cause of renal impairment

**eGFR >6 ml/min/1.73 m²** with complications resistant to conservative treatment

- Volume overload or uncontrollable HT
- Hyperkalemia, metabolic acidosis, anemia
- Uremic encephalopathy, pleuritic, pericarditis
- Nausea/vomiting, wt loss, malnutrition

Is it difference between 30 YO and 86 YO CKD patients?

NST indication for dialysis in CKD 2012
## Average Life Expectancy

<table>
<thead>
<tr>
<th>Age, y</th>
<th>Prevalent Dialysis Population</th>
<th>General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>4.6</td>
<td>15.5</td>
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<tr>
<td>70-74</td>
<td>3.9</td>
<td>12.1</td>
</tr>
<tr>
<td>75-79</td>
<td>3.3</td>
<td>9.1</td>
</tr>
<tr>
<td>80-84</td>
<td>2.7</td>
<td>6.5</td>
</tr>
<tr>
<td>&gt;85</td>
<td>2.2</td>
<td>3.4</td>
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KDIGOs: definition of conservative kidney management

Planned holistic patient-centered care for CKD G5 (No dialysis)

1) Interventions to delay progression of kidney disease and minimize risk of adverse events or complications

2) Shared decision-making

3) Active symptom management

4) Detailed communication including advance care planning

5) Psychological support

6) Social and family support

7) Cultural and spiritual domains of care

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Advance care planning allows for deliberate decision making.

Options

- By decision
- By default

RRT

- Opportunity for access placement
- Risks associated with emergent start
- Subtle escalation of symptoms

No RRT

- By decision
- By default

- Active management
- Palliative management
- Acute symptoms

- Timely non-emergent dialysis start
- Emergent start
- Hospice
- Death

Tell-Tell-Tell

Health care team

Patient

Lover
Shared decision-making for the advance care planning process in ESRD

- Initiate advanced care planning early on in the continuum of CKD.
- Assure patient has decision making capacity and the cognitive capacity to comprehend.
- Engage the patient’s family (if appropriate and desired) in the decision making process.
- Consider issues specific to age and overall health status in informed consent discussions.

- Present estimate of renal and overall prognosis with and without dialysis.
- Present anticipated changes in functional status with and without dialysis.
- Describe the risks of dialysis including the potential for intra- and inter-dialytic distress.
- Recognize the relevance of patient’s life experience and tailor the discussion accordingly.

- Determine and agree on the patient’s goals, for both short-term and long-term care.
- Discuss modality and dialysis access options.
- Explain responsibilities of vascular access for hemodialysis or peritoneal catheter placement for peritoneal dialysis.
- Make plans for dealing with symptoms that could occur should kidney failure progress faster than anticipated.

- Discuss desires for acute symptom management and goal to avoid “heat of the moment” decisions.
- Integrate informed consent into decision making when deciding whether to pursue renal replacement therapy.
- Distinguish informed consent for the option of dialysis from that dedicated to the intra-dialytic symptoms.
- Respect and assure the integrity of the informed consent process.
Shared decision-making for the advance care planning process in ESRD

Initiate advanced care planning early on in the continuum of CKD.
Shared decision-making for the advance care planning process in ESRD

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Shared decision-making for the advance care planning process in ESRD

Engage the patient’s family (if appropriate and desired) in the decision making process.
Consider issues specific to age and overall health status in informed consent discussions.
Shared decision-making for the advance care planning process in ESRD

Present estimate of renal and overall prognosis with and without dialysis.
Surprise Question

“Would I be surprised if this patient died in the next year?”

150 hemodialysis patients,
“no” group 29.4% had died at 1 year
“yes” group 10.6% had died at 1 year

Shared decision-making for the advance care planning process in ESRD

Present anticipated changes in functional status with and without dialysis.
Integrating informed consent into the advance care planning process

Describe the risks of dialysis including the potential for intra-and inter-dialytic distress.
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Current patient decision aids for RRT decision-making

Shared End-Stage Renal Patients Decision Making (ShERPa-DM)
My Kidneys, My Choice
Yorkshire Dialysis Decision Aid (YoDDA)
Shared Decision Making
My Life, My Dialysis Choice
Kidney failure: What Type of Dialysis Should I Have?

Current patient decision aids for RRT decision-making (cont)

Kidney Failure: Should I start Dialysis

A Decision Aid for Patients: The choice of dialysis for the older person with End Stage Kidney Disease

Chronic kidney disease: treatment options (Option Grid)

‘All of the Facts’ Dialysis Decision Aid
New conservative kidney management-specific patient decision aids

Conservative Kidney Management Patient Decision Aid

Ottawa Tool

OPTIONS
Conservative Kidney Management Patient Decision Aid

Introduction
As your kidney function declines, one of your biggest choices is whether to get dialysis or conservative kidney management (CKM).

Dialysis is not for everyone. Dialysis can’t cure kidney failure, but it may help you live longer and feel better. The older and sicker you are, the less likely it is that dialysis will help you. Some people will live as long and feel better with CKM, which does not include dialysis.

It’s your choice whether to have CKM or dialysis.

This tool is to help you decide if CKM or dialysis is right for you. You can use it to talk with your healthcare team and loved ones about your decision.

It should take 15 to 25 minutes to complete. You can come back to it, or share it with someone you trust by using the email button or printing your responses. How you respond is anonymous and confidential.

http://www.ckmcare.com/Resources/Details/208
The following section of this tool will help you determine how CKM or dialysis may benefit you personally.

1. How old are you?
   - Under 60 years old
   - 60 - 69 years old
   - 70 - 79 years old
   - 80 years or older

2. Do you live in a nursing home or other long-term care facility?
   - Yes (<60)
   - No (<60)

http://www.ckmcare.com/Resources/Details/208
Conservative Kidney Management
Patient Decision Aid

**Older than 70 years**
Low kidney function (GFR 8-10 mL) from time of needing dialysis

**LIFE EXPECTANCY**

- **Conservative Kidney Management**
  - Time in hospital: ½ month
  - Time at home: 13 ½ months
  - Total Life Expectancy: 14 months

- **Hemodialysis** (Dialysis every other day)
  - Time in hospital: 2 months
  - Time at dialysis clinic: 14 months
  - Time at home: 18 months
  - Total Life Expectancy: 34 months

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http://www.ckmcare.com/Resources/Details/208
Mr. P

Mr P was a 74-year-old man with a solitary kidney, DM2, CAD and an ostomy after colon cancer resection.

His eGFR was 7 ml/min/1.73 m2 with symptoms of fatigue and anorexia.

He had a fistula created several years prior, and he was advised to start hemodialysis.

He was very anxious about the prospect of dialysis, particularly as he lived on a farm, which was a 30-min drive from the closest hemodialysis unit.
Mr. P

He met with a nurse who had received training in decision coaching, and they used a CKM-specific PDA. Among the values and preferences that were elicited were his desire to avoid travel, his belief that he had lived a full and good life and his desire to ‘die naturally’.

He chose not to start dialysis and palliative care was consulted. 2 years later, his eGFR was 5 ml/min/1.73 m², and he was increasingly symptomatic, so palliative care was provided in his home.

He died at home 1 month later.
Take Home Message

Shared decision-making is widely held to be the new standard of patient centered care in nephrology.

There are gaps in how well it is applied, especially in the context of decision making around RRT choices.

There is increasing development and use of Patient decision aid to facilitate shared decision-making around RRT choices.
Thank you