

Key highlights of the Renal Supportive Care Masterclass Melbourne

Key aspects required for a Renal supportive care service

- Must be an active program integrating palliative care and nephrology
- Evidence based symptom management
- Patient centred with shared decision making
- Requires skilled communication with provision of information including prognosis and treatment options
- Incorporate advance care planning
- End of life care for patients on conservative pathway and after withdrawal from dialysis

Key Nephrology skills required in Renal supportive care

- Management of symptoms of CKD
- Management of depression and anxiety
- Ability to discuss prognosis, goals of treatment and ceiling of care
- Management of dialysis withdrawal and end of life

Key Palliative care skills required in Renal supportive care

- Management of refractory symptoms, including complex depression, anxiety, and grief
- Conflict resolution between families (or staff) about goals of treatment
- Management of complex end of life care
- Assistance in causes of near futility

Key ideas in expanding or setting up a renal supportive care clinic based on the experience of various centres in Australia.

- Importance of flexibility of clinic, including home visits and being able to visit patients on dialysis.
- Keeping the clinic within the renal department, rather than in the palliative care department. To ensure familiarity and reduce associated stigma
- Mandating renal registrar presence in the clinics
- Monthly multi-disciplinary meetings to discuss difficult patients. This helps coordinate care as well as support staff
- Use 6-monthly surprise questions to prompt advance care planning in dialysis patients
- Send out the IPOS renal to dialysis patients every 6months to ensure symptomatic dialysis patients are not missed

Summary of evidence for dialysis decision making in older people

- There is increasing complexity in treatment decisions making in older patients
- Brown et al (2015)¹: Prospective observational cohort study
 - RSC non-dialysis patients (n=122) had a median survival of 16months vs pre
 - Survival advantage is lost for people over 75 years with 2+ comorbidities including ischaemic heart disease
 - No difference in symptom or QOL stability or improvement between dialysis and RSC care not for dialysis patients
- Morton et al (2012)²: 105 patients with CKD 3-5.
 - Travel restrictions and visits to hospitals were the two variables where patients preferred conservative management over dialysis, OR 0.47 and 0.70 respectively.
- Carson et al (2009)³: observational study comparing conservative (n=29) to dialysis (n=173)

- Conservative patients had significantly lower rates of hospital days per patient days survived. Haemodialysis patients spent almost half of the days they survived at or in the hospital compared to <5% in the conservative group.

Approach to discussing treatment options with families

- Challenges of discussing conservative care vs dialysis include: lack of data showing how dialysis may not benefit elderly patients with multiple comorbidities, uncertainty, difficulty predicting survival outcomes, competing interests of QOL including symptoms, functional status and time required for treatment / hospitalisations.
- Role of shared decision making where outcomes are uncertain
- Must consider more than just survival information. Patients want non-clinical and logistical aspects of treatment options e.g. PD fluid volume, boxes and storage; travel options etc.

Key points for symptom management in advanced CKD

- Dialysis does not fix all symptoms
- Fatigue is multifactorial in CKD and can be constant or post dialysis
 - Evidence based treatment options: Physical exercise, CBT and psychosocial interventions. No evidence for pharmacological management
 - Key aspects of management: accommodate activities, keep active, self-compassion and facilitation of active fatigue management
- Pain is present in >58% of CKD patients. Avoid NSAIDs if eGFR <35; and avoid codeine and morphine in advanced CKD. Other medications may need dose adjustments
- Itch is a disabling symptom, the mechanism of which is not completely understood. Histamine only plays a very small role, and central sensitisation can occur. Dermal mast cells (90% histamine independent) have a role in releasing of multiple pruritogens.
 - Risk factors: male, high calcium and phosphate. Diabetes, iron deficiency, anaemia, low albumin.
 - Treatable causes: anaemia, iron deficiency, dry skin, uraemic toxins (if on dialysis), drugs
 - Evidence based management: gabapentin 100mg post dialysis and up-titrate; non dialysis 100mg nocte and up-titrate. Evening primrose oil 1000mg BD.
 - Other: avoid hot showers, moisturise, pregabalin. Upcoming: difelikefalin
- Taste changes in CKD are related to salivary flow, pH and electrolyte composition
- Complex interactions between taste alterations and other GI symptoms including nausea, vomiting and anorexia

Key points for end of life care

- RSC patients can become very symptomatic at the end of life
- In the terminal phase:
 - cease unnecessary medications, continue important ones like anti-anginals and diuretics
 - cease unnecessary observations
 - consider route of medications
 - mouth care paramount
 - never forget some patients still pass urine so consider retention
- Consider the physical environment: single room, 24hr access, familiar photos/music, garden, access for (and discussion with) young children
- Emotional support with meticulous communication and remind the family about physical care for themselves e.g. are you eating/sleeping, you are each other's greatest allies look after each other
- Emotional/spiritual/religious counselling

References

1. Brown M, Collett GK, Josland EA, Foote C, Li Q & Brennan FP. CKD in Elderly patients managed without dialysis: survival, symptoms, and quality of life, *CJASN* 2015, **10**(2): 260-268.
2. Mortan R, Snelling P, Webster AC, Rose J, Masterson R, Johnson DW & Howard K. Factors influencing patient choice of dialysis versus conservative care to treat end-stage kidney disease. *CMAJ* 2012, **184**(5): E277-83.
3. Carson RC, Juszczak M, Davenport, A & Burns A. Is maximum conservative management an equivalent treatment option to dialysis for elderly patients with significant comorbid disease? *CJASN* 2009, **4**:1611-1619.