Editorial

Palliative Care of Renal Failure Patients

Long-term dialysis is a life-saving treatment for patients with end-stage renal disease (ESRD). In a minority of ESRD patients, however, the clinical conditions and level of self-sufficiency make the usefulness of dialysis questionable; it may even be futile, worsening quality of life or simply prolonging the dying process [1]. There is actually a substantial risk of death or functional decline within a relatively short period of time in elderly patients with advanced chronic kidney disease [2]. In high-risk highly dependent patients with renal failure, the decision to dialyze or not has little impact on survival; dialysis in such patients may result in unnecessary suffering before their unavoidable death. It is therefore reasonable for some patients to choose, in consultation with their physician, conservative (i.e. non-dialytic) management. In fact, the number of such patients is steadily increasing. Provisional estimates indicate that, in the UK, about 20% of predialysis patients referred for education select conservative management [3]; this proportion is comparable to that of our general impression. Clinical experience suggests that the health care needs of this patient population are complex. Good renal supportive care includes symptom control, measures to retard disease progression and manage complications of renal disease, provision of information, advance care planning, and addressing wider psychosocial and spiritual needs. Meeting these needs requires a shift from a predominantly disease-focused approach to a more patient-centered approach. Given the huge burden of ESRD and the high cost of treatment, however, there is a serious need for solid data that can help in deciding whether or not conservative therapy should be recommended over long-term dialysis [4]. In this respect, palliative care physicians have an important role to play in educating nephrologists about palliative care. Dr. Doris Tse's article in this issue of the *Hong Kong Journal of Nephrology* provides important data for our reference, as well as substance for our thinking [5].

In her paper, Dr. Tse describes the renal palliative care program developed in a local center as an option for those who may not benefit from dialysis or who do not prefer dialysis. The program is an interdisciplinary one that involves collaboration between palliative and renal medicine specialists, with the aim of discussing advance care planning related to treatment benefits, burdens, predicted prognosis and the patient's preference. Specialist palliative care is also introduced as a treatment option.

The result of the program was impressive. Over 1.5 years, a total of 96 patients were interviewed for advance care planning—two thirds of them chose palliative care after discussion. Holistic care, including home care in some cases, was provided by a multidisciplinary team. On the whole, the program was well received by patients and their families. Notably, active palliative care while forgoing dialysis helped to alleviate the sense of helplessness and abandonment; patients and families rarely changed their minds after a decision for the non-dialytic approach was made.

The program described by Dr. Tse clearly illustrates how palliative care could be provided for ESRD patients. Much of what the palliative care physician offers is prognostic data—both with regard to ESRD and to the common comorbidities that set the problem in a larger context. Palliative care professionals have a great deal to offer ESRD patients and their families. Opportunities for advance care planning is discussed by Dr. Tse, which aims to provide an open forum where patients, their families and nephrologists can discuss the various options available to them when they are struggling with decisions on whether dialysis would serve to prolong life or merely delay death.

Another important message of the article is that choosing against dialysis does not equate to choosing to have no treatment. In general, as nephrologists, we receive little training in the way of palliative care. There is good evidence to indicate that symptoms, especially pain, are both under-recognized and undertreated in renal failure patients, who themselves usually identify adequate pain and symptom management as a vital component of quality end-of-life care [6]. It is, however, important to realize that literature on symptom prevalence is largely limited to the dialysis population, and little is known about symptoms in the conservatively managed patient [7]. It is likely that patients managed conservatively have high levels of comorbidity and poor functional status, and therefore have a higher overall burden of symptoms than dialysis patients. A recently published study, the first to be conducted in this population, suggests that the prevalence of symptoms in conservatively managed patients is high [8].

A few important issues related to the palliative care of ESRD patients have not been addressed in Dr. Tse's paper, and further research is needed. First, the life expectancy of conservatively treated patients needs to be defined. Surprisingly, there is little published data on the life expectancy of patients with advanced chronic kidney disease who are treated conservatively. In a recent study, the reported median overall survival in patients with advanced renal failure treated conservatively was

around 2 years. Although dialysis is generally associated with longer survival in patients aged over 75 years, those with multiple comorbidities, ischemic heart disease in particular, do not survive longer than those treated conservatively [9,10]. To date, there is a paucity of local data on the life expectancy of conservatively managed ESRD patients.

More importantly, the role of the palliative care specialist after the initiation of dialysis has not been explored. In addition to being involved in advance care planning, palliative care specialists could advise patients and families to stop dialysis, and provide support for those patients in whom further dialysis is unlikely to meet the patient's goals. At present, around 10% of ESRD patients are recorded to die as a result of *termination of dialysis*, presumably due to severe coexisting diseases and poor general condition. There is certainly room for improving the quality of care of these patients from the participation of palliative care physicians. Nonetheless, the program outlined by Dr. Tse is a small but significant step towards providing better care to patients with kidney diseases, and is an example of how holistic care can be achieved for our patients.

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