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PD AS A PALLIATIVE THERAPY

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DISCLOSURES

- Speaker has received honoraria from:
  - AMGEN
  - Abbott

PD AS A PALLIATIVE THERAPY

"Thinking Outside the Box"

Learning Objectives

1. **Identify patients with advanced, life-limiting co-morbid conditions who may benefit from PD as a therapy to improve symptom management.**

2. **Discuss how PD can improve quality of life and optimize time at home for patients doing poorly on conventional hemodialysis.**

PATIENT JOURNEY
'CLIFF'

- **Nov. 2005: Initial Nephrology Consult**
  - 70 y/o retired salesman, Type 1 DM since age 38; eGFR 42 ml/min, high grade proteinuria
  - Supported by wife (32 yrs), 4 children, 3 stepchildren
  - Comorbidities:
    - HTN, Neurogenic bladder (self-caths), chronic foot ulcer, CAD, mild aortic stenosis, atrial fibrillation, TIA (anti-coagulated), bilateral inguinal hernia repair
- **Feb. 2009: 'expresses desire to do PD'; eGFR 24 ml/min**
  - Referred for modality education at KCC

PATIENT JOURNEY
'CLIFF'

- **Jan. 2013, eGFR 14 ml/min**
  - "not a PD candidate due to multiple comorbidities"
  - Referred for vascular access creation
- **March 2013 - urgent HD start, tunneled CVC as access**
- **July 2013 – "patient still wants PD"; booked for PD catheter insertion, but deferred b/c moving, wife away**
- **Sept 2013 – "plan for PD deferred indefinitely"**
  - Severe cachexia, deconditioning, frequent falls, infected foot ulcers
  - CVC problems (poor flow), orthostatic hypotension post HD

PATIENT JOURNEY
'CLIFF'

- **Oct. 2014 – "patient still wants PD"**
  - **PD catheter insertion deferred b/c infected foot ulcer, UTI**
- **Apr. 2015**
  - **Fractured left arm d/t fall, PD plans deferred**
  - **Unable to achieve DW on HD, needing extra runs for pulmonary edema**
- **July 2015**
  - **Echo demonstrates severe aortic stenosis, referred to Cardiology**
- **Sept 2015 – "patient expressed intense dislike of HD, wants PD"**

PATIENT JOURNEY
'CLIFF'

- **Jan 2016**
  - Elective aortic balloon valvuloplasty – complicated by ACS/cardiogenic shock, emergency PCI; not a surgical candidate
- **Feb 2016**
  - Bedside PD catheter insertion (finally!!!!)
  - Completed PD training March 2016
- **Mar-Aug 2016** - no hospitalizations, traveled to Parksville, visits with family
- **Aug 2016** – "patient agreeable to Hospice referral"
  - Clinic visit following short admission for rapid a.fib
  - HR high 30's, SBP 70's; severe weakness, chest pain, dyspnea, fatigue

PATIENT JOURNEY
'CLIFF'

- **Sept. 12, 2016 – Palliative Care Consult**
  - **Patient's expressed wishes:**
    - **To continue medical Tx for reversible conditions, but no CPR**
    - **Stay at home, enjoy good quality of life for as long as possible**
    - **Not be a burden to his wife**
    - **"He is hoping to take his wife out for dinner tonight"**
- **Sept. 21, 2016 – PD Clinic visit**
  - **Symptoms well controlled, patient/wife 'feel supported, relieved'**
- **Sept. 25, 2016 – patient died peacefully at home**

WHAT IS PALLIATIVE CARE?

- **Adapted from Canadian Virtual Hospice:**
  - **‘Palliative care is a type of specialized health care for patients and families facing life-limiting illness’**

    (Stage 5 CKD is one such illness)

  - **Palliative care helps patients achieve the best possible quality of life right up until the end of life**

WHAT IS PALLIATIVE CARE?

- **Quality palliative care encompasses the following:**
  - Focuses on the concerns, hopes and fears of patients & families
  - Pays close attention to symptoms such as pain, nausea, confusion, loss of appetitie
  - Considers the emotional and spiritual concerns of patients
  - Ensures that care is respectful and supportive of patient dignity and autonomy
  - Respects the social and cultural needs of families
  - Uses a multi-disciplinary approach that may include: social workers, spiritual leaders, pharmacists, dieticians, nurses, physicians

WHAT IS A PALLIATIVE APPROACH TO DIALYSIS CARE?

- **Grubb et.al., CJASN Aug, 2014**

  (J. Perl, S.V. Jassal, R. Mehrotra also authors)

  ‘….a transition from a conventional disease-oriented focus on dialysis as rehabilitative treatment to an approach prioritizing comfort and alignment with patient preferences and goals of care to improve quality of life and reduce symptom burden for maintenance dialysis patients in their final year of life.’

WHAT IS A PALLIATIVE APPROACH TO DIALYSIS CARE?

- **Moves away from:**
  - **Standard Quality Metrics such as Kt/V, 'optimal' PO4/PTH, 'optimal' Hgb**
- **Moves toward:**
  - **Patient-centered Quality Metrics:**
    - **Amelioration of physical symptoms/minimizing suffering**
    - **Patient and caregiver satisfaction***
    - **Minimize psychosocial stressors (for patients and caregivers)**

***Studies suggest patient satisfaction with care correlates with perceived QOL and disease burden (Kirchgessner et.al. Kidney Int. 70, 2006)**

WHO MAY BENEFIT FROM A PALLIATIVE APPROACH?

- Patients who have an expected survival of less than 1 year
  - How to predict????
    - Prognostication tools:
      - Cohen Model (age, serum albumin, dementia, PVD, 'surprise question')
      - Charlson Comorbidity Index (age, albumin, 22 comorbidities, incl. CHF, PVD, CVD, DM, Malignancy, Liver Ds, AIDS)
  - Patient expressed wishes
    - "Treat reversible conditions, but no heroics"
    - "I know I would die without dialysis, and I don't really want dialysis, but I'm not ready to die yet…."

WHO MAY BENEFIT FROM A PALLIATIVE APPROACH?

- **Based on small studies and shared experiences with colleagues, PD may be effective for:**
  - **Patients with refractory CHF/cardiorenal syndrome**
  - **Patients with multiple myeloma or amyloidosis**
  - **Patients with advanced/metastatic solid organ malignancy**
  - **Patients with advanced liver disease with refractory ascites**

HOW ARE WE DOING?
(Re: Palliative Approach)

- **In the last month of life for dialysis patients, rates of hospitalization are 76%, for ICU admission, 49%** **(Wong et.al. Arch Int Med 172, 2012)**

- **Davison S, CJASN, 2010**
  - **Majority of patients with Stage 5 CKD preferred care to focus on decreasing pain and suffering**
  - **Only 18% favored dialysis to extend their lives**
  - **More patients wished to die at home (36%) or in an inpatient Hospice (29%) than in a hospital (27%)**

- **It appears current patterns of death and treatment intensity are not congruent with patients' wishes**

ARGUMENTS SUPPORTING PD AS A PALLIATIVE THERAPY

- **Focuses on ‘what matters most’ to the patient**
  - **Time at home**
  - **More time with family**
  - **Longer survival**
  - **Opportunity to travel**
- **Can improve symptoms**
  - **Nausea, confusion, anorexia, pruritis, pain, dyspnea (effective Tx for refractory CHF)**
- **Respectful of patient autonomy, dignity**
- **Multi-disciplinary team addresses emotional, spiritual, cultural and social needs of patients and families**

ARGUMENTS AGAINST PD AS A PALLIATIVE THERAPY

- **‘Futility’**
  - **“when physicians conclude (either through personal experience, consultation with colleagues, and/or empiric data), that in the last 100 cases, a treatment is useless”**
- **Potential for harm (peritonitis, hernias, leaks)**
- **Economic***
- **‘Wasteful’ of limited resources***

*CAN WE AFFORD THIS?
(Wouldn't it be cheaper to not dialyze at all?)

- Annual cost of PD is approx. $50,000 - $55,000
- For patients with 'terminal' illness, rates of hospitalization in the last month of life vary between 60-65%, admission to ICU in 20-50%
- What if we could reduce number of hospital admissions by treating with PD? (compared to palliation alone?)
  - Example: PD for refractory cardiorenal syndrome (Nakayama, PDI 2013)
    - Mean hospital time reduced 3.7-fold following initiation of PD, most pts improved from NYHA III/IV to I/II (Rychelynck et.al. Adv.Perit.Dial 1997)

NEXT STEPS: CALL TO ACTION

- We (nephrologists and care team) are responsible for initiating discussions re: goals of care, patient wishes (for near and distant future)
  - **Serious Illness Conversation Guide, Ariadne Labs
- When preference for PD indicated, we need to enable this to come to fruition
- If a patient is suffering/declining on conventional HD, consider a switch to PD
- We (collectively) need to ‘shift’ to patient-focused Quality Metrics

CONCLUSIONS

- PD may be the best option in taking a palliative approach to the delivery of dialysis care for patients with limited life expectancy
- **Patient-centered** >>> Disease-oriented
- PD can alleviate suffering
- PD is more likely to align with patient wishes (vs facility-based HD)