Comprehensive Conservative Care

Setting the scene

Mr AM age 75

- CKD for 13 yrs
- MI 2002, coronary stents x 4 in 1996 and 2002;
  - aortic regurgitation & diffuse LV hypokinesis
- Fem-pop bypass 1994; angioplasty 2002
- Ex-smoker; hyperlipidemia; hypertension; gout
- CLL
- Underwent CABG 2007
  - Post –op occipital stroke
  - Endoluminal Repair thoracic AA
    - Post –op MI & pulmonary edema

- **Stage 5 ESKD 2 years later – should he have dialysis?**

1. Would this man be dialysed in your Unit?

2. Would YOU recommend dialysis to this man?

   - If so, why?

   - If not, why not?

Key questions

1. What will happen to him if we don't dialyse him?
2. What will happen to him if we dialyse him?
3. What can we do for him if we don't start dialysis?

Comprehensive Conservative (non-dialytic) Care KDIGO

Holistic patient centred care at Stage 5 CKD, including:

1. Delay progression of CKD
2. Shared decision making

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3. Delay progression of CKD
4. Active symptom management
5. Detailed communication, including ACP
6. Psychological support
7. Social & family support
8. Cultural & spiritual domains of care

Does NOT include dialysis

Davison et al. Kidney Int. 2015; 88: 447-59

The key elements of RSC :

1. **An active program - alignment of nephrology and palliative care – A TEAM**
   – renal and palliative care physicians, nurses, and allied health staff such as dieticians and social workers,
   – underpinned by education, research, and quality assurance;
2. **Meticulous and evidence-based symptom management**
   – with or without dialysis;
3. **Shared decision-making,**
   – skilled communication,
   – provision of information including prognosis,
   – informed decision-making regarding dialysis,
   – Or, opting for conservative non-dialysis pathway;

The key elements of RSC :

4. Provision of **active patient-centred care** for patients with ESKD who are planned for a conservative, non-dialysis pathway, addressing physical, psychosocial and spiritual needs
5. **Advance care planning** for patients with ESKD,
   – on dialysis
   – on a conservative pathway
6. **End of life care** for patients on a conservative pathway or following withdrawal from dialysis

What does a RSC program look like?

- 2 clinics per week + inpatient, home, phone services
- ***Palliative care specialist as part of Renal department***
- Clinical Nurse Consultant, dietitian & social worker
- Integrated holistic patient care
  - Emphasis on symptom control, nutrition, QOL & ACP
- **Registrar & Junior doctor training**
- **Continuation of ‘usual’ nephrology care – NON-ABANDONMENT**

What does a RSC program look like?

- Development of ‘palliative care’ treatment list for ESKD
- Local website
- education programs & symposia
- memorial service
- RESEARCH

It’s easier to offer dialysis

“Honestly? I prefered it when we didn’t talk about the elephant.”

Decision making

The main initial concern of patients and families:

what is the likely survival with or without dialysis?

Life expectancy on renal replacement therapy for elderly patients

Australia and New Zealand Median survival of incident dialysis patients by age Based on 2017 ANZDATA		
Survival in years	Australia	New Zealand
65-74	4.6	3.7
75-84	3.5	2.9
85+	2.2	1.9
Median survival is lower if patients have vascular disease and/or diabetes		

Survival on dialysis

Age group	1 year	5 year
Australia – incident dialysis patients 2007-2016. % survival (95% CI)		
65-74	88 (87-89)	**50 (48-51)**
75-84	83 (82-84)	**33 (32-35)**
85+	72 (69-76)	**20 (16-24)**
Australia – cancer patients 2009-2013. 5 year survival		
Breast Cancer (aged 75+ at diagnosis)		**79% vs. 33%**
Colorectal Cancer (aged 75+ at diagnosis)		**61% vs. 33%**
Lung Cancer (aged 75+ at diagnosis)		**10% vs. 33%**

Conservative Management and End-of-Life Care in an Australian Cohort with ESRD

Clin J Am Soc Nephrol 11: 2195–2203, 2016.

Rachael L. Morton, Angela C. Webster,† Kevin McGeechan,† Kirsten Howard,† Fliss E.M. Murtagh,‡ Nicholas A. Gray,§ Peter G. Kerr,‖ Michael J. Germain,¶ and Paul Snelling***

Abstract

Background and objectives We aimed to determine the proportion of patients who switched to dialysis after confirmed plans for conservative care and compare survival and end-of-life care among patients choosing conservative care with those initiating RRT.

PINOT study patients enrolled over 3 months 2009 followed over 3 years

From 66 Renal Units in Australia – dialysis, transplant, CM patients

102/721 (14%) conservative care – mean age 79 vs 61 yrs.

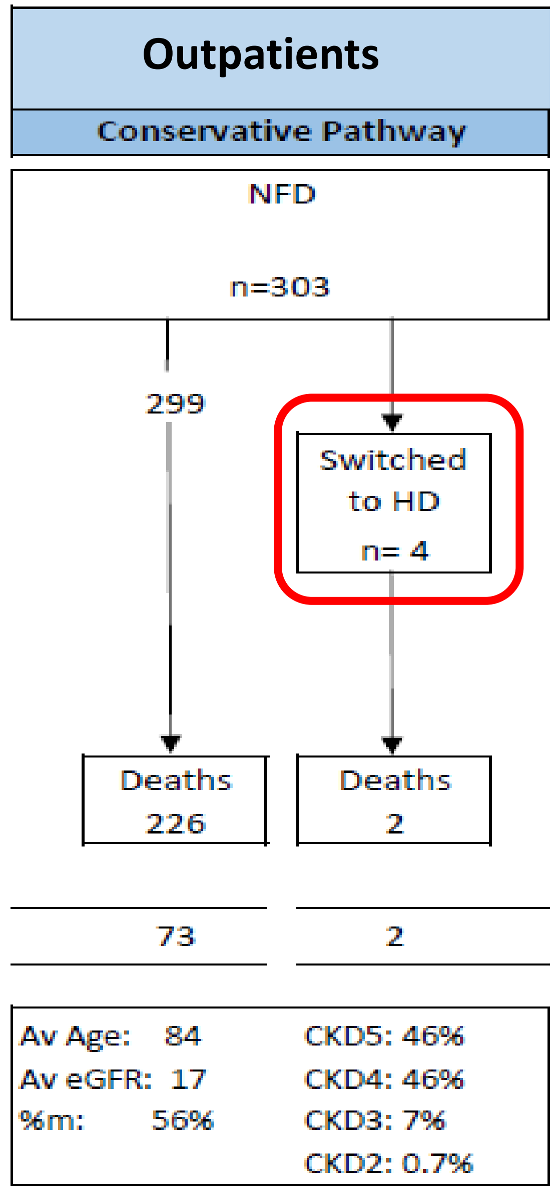
Health
South Eastern Sydney
Local Health District

Summary – Australian data

1. <10% who choose CM switch to RRT in 3 years
2. 1 in 5 CM patients with ESKD (eGFR <15) still alive after 3 years
3. For whole cohort factors associated with death
   - Older Age
   - Low serum albumin at start
   - CM (vs. RRT)
4. Those managed with RRT who died less likely to receive Palliative Care except in last week of life
5. Most common cause of death in RRT was withdrawal from dialysis
6. 43% of Australian nephrology trainees feel well trained in RSC

Clin J Am Soc Nephrol 11: 2195–2203, 2016.

March 2009 to May 2018: managed 520 outpatients, 220 inpatients with RSC



Ethical principles for patients, families and doctors to consider

At its heart, ethics asks a simple question:

In the circumstance of this patient what is the right thing to do?

Discussing Conservative Management With Older Patients With CKD: An Interview Study of Nephrologists

AJKD Vol XX | Iss XX | Month 2017

Keren Ladin, Renuka Pandya, Allison Kannam, Rohini Loke, Tira Oskoui, Ronald D. Perrone, Klemens B. Meyer, Daniel E. Weiner, and John B. Wong

CM Discussions Not Integrated in Usual Care	
• Rarely discuss CM	• Limited patient engagement in decision making
• CM not presented neutrally	• Lack of uniform approach to CM conversations among nephrology team
• Focus on active treatment	• Confronting institutional barriers

"Rarely would we say that we don't think [dialysis is] possible." (Participant ID 7, male, >10 years in practice)

Does such a program work?

CKD in Elderly Patients Managed without Dialysis: Survival, Symptoms, and Quality of Life

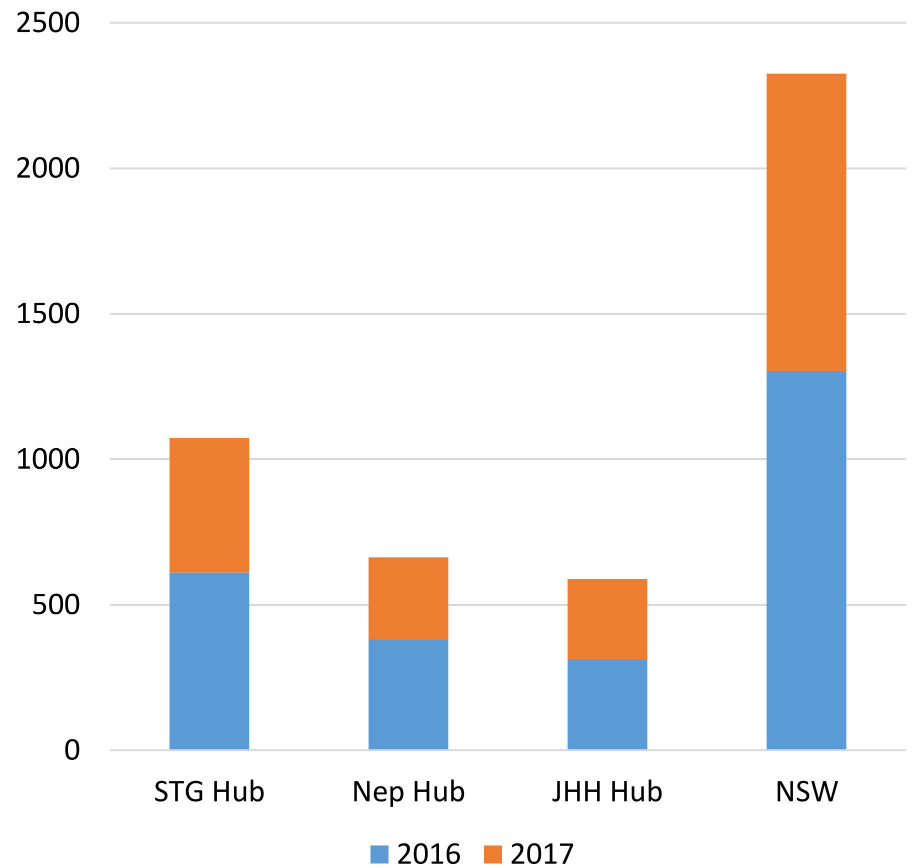
Mark A. Brown,† Gemma K. Collett,* Elizabeth A. Josland,* Celine Foote,‡ Qiang Li,‡ and Frank P. Brennan**

CJASN February 06, 2015 vol. 10 no. 2: 260-268

NSW & National

Number of patients seen by Renal Supportive Care Services

		No. patients seen by Renal Supportive Care Services
STG Hub	2016	611
	2017	462
	STG Hub Total	**1073**
NEP Hub	2016	382
	2017	281
	NEP Hub Total	**663**
JHH Hub	2016	311
	2017	278
	JHH Hub Total	**589**
NSW	2016	**1304**
	2017	**1021**
	NSW Total	**2325**



Symptoms - 2017

Improved symptoms (iPOS Renal)

- 53% of conservative patients

- 58% of RRT

  - between first and most recent visit,
    - on average 5 months

Quality of Life

Maintained or improved (EQ 5D 5L)

- 66% of conservative patients

- 63% of RRT

  - between first and most recent visit,
    - on average 5 months

Nutritional Status

Maintained or improved (SGA)

- 74% of conservative patients
- 75% of RRT
    - between first and most recent visit,
        - on average 5 months
- Overall about 30% improved nutritional status

Ultimate aim of the RSC program

1. All nephrologists will be skilled in basic Renal Supportive Care
2. Conservative non-dialysis management will become a ‘usual’ option for ESKD alongside dialysis & transplantation
3. Patients and families will feel more comfortable with such choices

Primary and Specialist Palliative Care Skills

Primary palliative care skills for the nephrologist
1. Basic management of common symptoms in ESKD 2. Basic management of depression and anxiety, and psychosocial issues 3. Basic discussions about • Prognosis • Goals of treatment • Ceilings of care 4. Basic management of dialysis withdrawal and end of life care
Specialist palliative care skills
Management of refractory symptoms Management of more complex depression, anxiety, grief, and existential distress Assistance with conflict resolution regarding goals of treatment within families, and between families and staff Assistance in addressing cases of near futility

adapted from Quill et al. NEJM 2013

What happened to Mr AM ?

- **2 more years later**
  - Did not have dialysis; had RSC team
  - Died peaceful death following further MI and hypotension
  - Family present and supportive

  - 4 years after initial referral
    - 3 hospital admissions
  - 18 months after GFR 10
  - 12 months after GFR 8

Renal Supportive Care

“ The right treatment

For the right patient

At the right time of their life”