Original Article

Symptom Burden and Associated Factors in Renal Transplant Patients in the U.K.

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Abstract

Context. Renal transplantation is gold standard care in end-stage kidney disease, but little is known about symptom prevalence in transplanted patients.

Objectives. This study assesses symptom prevalence in this population.

Methods. This was a U.K.-based, cross-sectional symptom survey of end-stage kidney disease patients transplanted more than one year previously. Patient-reported data were collected using the renal Patient Outcome Scale. Demographic/clinical data also were collected, including estimated glomerular filtration rate (eGFR), renal diagnosis, and comorbidity.

Results. One hundred ten patients participated; mean age was 47 years (SD 13.6), and mean eGFR was 46 mL/min (SD 16.8, range 14–101). Symptom burden was high, with a mean of seven symptoms, but marked variance (SD 5.2, range 0–22). The most prevalent symptoms were weakness (56%, 95% CI 47–65), difficulty sleeping (46%, 95% CI 37–56), dyspnea (42%, 95% CI 33–51), feeling anxious (36%, 95% CI 28–46), and drowsiness (36%, 95% CI 28–46). Certain symptoms—weakness, difficulty sleeping, dyspnea, and drowsiness—were commonly reported as severe. A significant inverse relationship between renal function, as measured by eGFR, and number of symptoms ($P < 0.05$) emerged.

Conclusion. For renal transplant recipients, symptom burden is similar to dialysis, although with less pain, anorexia, and immobility. Routine symptom assessment should be undertaken in transplant patients to identify these often undisclosed symptoms. J Pain Symptom Manage 2012;44:229–238. © *2012 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Key Words
Dyspnea, drowsiness, energy, kidney transplantation, symptoms

Introduction

Renal transplantation is the treatment of choice for patients in end-stage renal failure. The number of transplantations performed annually is steadily increasing: total kidney transplants performed in the U.K. rose 7% between 2005 and 2007.[1] Decisions about the

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relative benefits of transplantation may be difficult in some patients. This may depend in part on the symptomatic improvement after transplantation.

Patients with advanced chronic kidney disease managed with or without dialysis have been shown to have a heavy symptom burden.[2,3] It might be expected that patients who have received definitive curative treatment (i.e., renal transplantation) would have a low symptom burden. However, few detailed data exist on symptom burden after transplantation.

Over 50 studies encompassing a total of 36,000 patients have assessed quality-of-life differences between dialysis and transplant patients using the Short-Form 36 (SF-36®) health survey.[4,5] However, such quality-of-life measures do not reflect the detail of symptom prevalence, severity, or overall burden. The SF-36 surveys patients on eight domains: Bodily Pain, General Health Perceptions, Mental Health, Physical Functioning, Role Limitations due to Emotional Functioning, Role Limitations due to Physical Functioning, Social Functioning, and Vitality[5] but captures few of the symptoms that renal transplant patients may experience. The Physical Functioning domain addresses mobility symptoms, Bodily Pain addresses pain symptoms, and Mental Health addresses symptoms of anxiety or depression.[6] However, the survey gives only a rough overview,[5] and many common symptoms, such as decreased appetite, vomiting, and diarrhea, which may be significant in transplant recipients, are not assessed.[6]

Information regarding further symptoms is scarce: to our knowledge, no studies have addressed in detail the breadth and quantity of symptoms that affect this population. There have only been a few studies on symptoms in transplant patients and those have focused on the prevalence of individual symptoms, not the total symptom scale.[7–12]

To address this issue, this study aimed to identify symptom prevalence, severity, and total symptom burden in renal transplant patients, whether symptom clusters existed, and the relationship of symptoms to comorbidity and renal function.

Methods

Patient-reported symptom data were collected from patients attending the transplant clinic in one U.K. renal unit during December 2009 and who were transplanted at least one year before study entry. All transplant patients without active rejection attending for follow-up at the transplant clinic were approached for enrollment.

Data were collected using the renal version of the Patient (or Palliative care) Outcome Scale symptom score-renal (POSs-renal). This patient-completed instrument identifies the presence and severity of 17 symptoms in the previous three days. Nine further transplant-specific symptoms (derived from clinical experience) were added: seven physical (headache, increased appetite, weight gain, weight loss, bloating, tremor, and poor libido) and two psychological (guilt and dissatisfaction with body image) without altering the scale's integrity and format. The questionnaire also provided three open fields, enabling patients to add any symptoms not listed that they had been experiencing over the last three days. The patient rated each symptom as absent, mild, moderate, severe, and overwhelming. The end of the questionnaire asked which symptom affected the patient the most and which symptom, if any, improved the most.

We also collected data on clinical outcomes of the renal transplant. The estimated glomerular filtration rate (eGFR; computed using the six-point Modification of Diet in Renal Disease formula[13]) was recorded the same day the patient completed the questionnaire to determine if the renal graft was functioning successfully. Primary renal diagnosis was categorized in accord with the U.K. Renal Registry classification.[14] The level of comorbidity was determined using the Davies scale, and the patient was graded as low risk if no comorbidities were present, medium risk if one to two comorbidities were present, or high risk if three or more comorbidities were present.[15] The Davies scale takes into account seven active comorbidities: malignancy (active, noncutaneous), ischemic heart disease (e.g., previous myocardial infarction, angina pectoris, and/or positive diagnostic procedure), peripheral vascular disease (distal aortic, renovascular, lower limb, and cerebrovascular disease), left ventricular dysfunction (clinical evidence of pulmonary edema not caused by fluid imbalance and/or moderate-to-severe left ventricular dysfunction on echocardiography), diabetes

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