Conservative Care of the Elderly CKD Patient: A Practical Guide

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Palliative care is a branch of medicine dedicated to the relief of symptoms experienced during the course of illness. Renal palliative medicine or kidney supportive care is an evolving branch of nephrology, which incorporates the principles of palliative care into the care of CKD and ESRD (dialysis, transplant, and conservatively managed) patients. Conservative (non-dialytic) management is a legitimate option for frail, elderly CKD patients in whom dialysis may not lead to an improvement in quality or duration of life. Patients with advanced CKD have a high symptom burden that often worsens before death. Palliative or supportive care by visiting nurses, palliative care programs, or knowledgeable CKD programs should be routine for conservatively managed CKD patients. Decision-making about dialysis or conservative management requires patients and families be given information on prognosis, quality of life on dialysis, and options for supportive care. Advance care planning is the process by which these issues can be explored. In addition to advance care planning, because patients with ESRD have a high symptom burden, this needs to be addressed. Patients with ESRD have a high symptom burden, which needs to be addressed in any treatment plan. Common symptoms include pain, fatigue, insomnia, pruritus, anorexia, and nausea. Symptoms appear to increase as the patient nears death, and this must be anticipated. Recommendations for management are discussed in the article. Hospice care should be offered to all patients who are expected to die within the next 6 months, and supportive care should be provided to all CKD patients managed conservatively or with dialysis.

Key Words: Palliative care, Advance care planning, Hospice, Kidney disease, End-of-life care

INTRODUCTION

The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".[1] Patients receiving palliative care are not necessarily at the end of life, and palliative care can be incorporated into the overall care plan in all stages of illness. Life-extending therapies can continue while supportive care is provided. The recent executive summary of the KDIGO Conference on Supportive Care in CKD outlines a working plan to address the issues of supportive care in CKD and defines the preference for the term supportive care as opposed to palliative care.[2] Our discussion will focus on supportive or conservative care of the elderly CKD patient, beginning with establishing goals of care, through symptom assessment and management, to end-of-life care and hospice. Our hope is that the discussion serves as a practical management tool.

DISCUSSION

Establishing Goals of Care, Communication, and Advance Care Planning

Patients and families who choose a conservative, non-dialytic plan of care reach that decision after discussions with nephrologists and possibly others such as primary care providers, social workers, and nurses familiar with CKD and its course. The primary feature of these discussions is to establish the goals of care. The process by which this is achieved is advance care planning.[3] To be effective, this process relies on patient-centered decision-making in large part based on information provided by the nephrologist. Choosing a conservative plan of care requires informed decision-making. It is incumbent on the nephrologist and the multidisciplinary nephrology team to communicate information required to make such decisions. This information includes an estimate of prognosis, a clear description of dialysis and non-dialysis options, including risks and benefits as well as side effects, and assurance that ongoing symptom management and care will continue, regardless of the treatment choice (dialysis or conservative) made. Predicting when death will occur for an individual patient is impossible, but estimating prognosis based on an integrated mortality model can be provided and is useful for decision-making. It is clear that older age adversely affects ESRD survival, as does functional status, poor nutritional status, comorbidity, and answering "no" to the question, "Would I be surprised if this patient dies within the next year?".[4-8] Defining an elderly dialysis patient as ≥75 years of age, less than 50% of the elderly who begin dialysis will be alive a year later.[4] The expected remaining years of life for dialysis patients aged 70 to 74 is 3.9 years, compared with 12.1 years for the same aged individual in the general US population.[4] For a dialysis patient aged 75 to 79 years, the expected remaining years of life is 3.3, compared with 9.1 for age-matched non-dialysis patients in the US

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population.[4] Several mostly single-center studies show that the elderly who begin dialysis live longer than those who do not except those with ischemic heart disease in whom dialysis does not extend survival.[9-11] Although validated only in hemodialysis patients, touchcalc is an available resource to estimate prognosis of an individual patient[12] (applications available at www.touchcalc.com and www.qxmd.com). It incorporates age, serum albumin, the presence/absence of dementia and peripheral vascular disease, and the surprise question ("Would I be surprised if this patient died within the next year?") to estimate 1-year survival, which can be shared with the patient and family. Even if they survive, elderly ESRD patients' functional status will likely deteriorate, especially if they live in a nursing home at the time of dialysis initiation.[13,14] The process of advance care planning can facilitate dialysis decision-making for patients and families by focusing on what is important to the patient within the context of prognosis and the expected quality of life. An individual's values will influence their goals and treatment preferences. Table 1 summarizes some questions that can be used to elucidate values and goals of care to assist in the process of advance care planning and the development of advance directives when appropriate. A communication framework for dialysis decision-making for frail elderly patients has recently been described and may serve as a useful template for nephrologists.[15] As with advance care planning in general, this framework focuses on the patient's goals and values using a patient-centered approach incorporating patient's hopes and expectations and prognostic information supplied by health-care providers.[15] Nephrologists may not be comfortable or adept at communicating end-of-life issues,[16,17] but these skills can be learned.[18] Because it is usually the nephrologist who raises the topic of dialysis, it is reasonable for the nephrologist to include conservative management among the choices presented to the elderly patient and his or her family. The clinical practice guideline, Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis,[19] includes guides to assist the nephrologist with these conversations. Tool kits are also available to ensure decision-making capacity and to evaluate quality of life.[19] The Coalition for Supportive Care of Kidney Patients also has relevant practical tools on their Web site (www.kidneysupportivecare.org).[20]

The contemporary focus on patient-centered care is leading to novel considerations of dialysis or conservative care as end points in decision-making for patients and families.[2,21,22] The goals of patients and families within the context of prognosis can be addressed by moving away from disease models of care, which have traditionally been followed and to a more patient-centered model of care. This leads to management decisions more focused on quality of life than simply on survival.[22] Determining whether dialysis is a bridge to transplantation, a long-term maintenance therapy, a final treatment destination, or unacceptable by life quality standards will assist in decision-making and institution of ongoing active supportive care depending on the goals of a particular patient and/or family.[22] Optimal conservative management of CKD may involve experts in palliative care, primary care physicians, and nephrologists, depending on the individual situation. Symptoms appear to be as common in conservatively managed CKD patients as they are in those on dialysis.[23] Multidisciplinary CKD clinics, if available, may standardize palliative care and focus on treatable symptoms.

CLINICAL SUMMARY

- Conservative, non-dialytic management is a legitimate option for frail, elderly CKD patients in whom dialysis may not lead to improvement in quality or duration of life.
- Advance care planning is a process of communication leading to decisions about goals of care and requires provider input about prognosis, options for care, and assurance for ongoing management regardless of choices made.
- Assessment and management of the high symptom burden in CKD is an integral aspect of conservative management.

Hospice

Hospice is a part of palliative care medicine that deals specifically with the end of life. At the time of enrollment in hospice, patients are usually no longer on curative or life-saving treatments, and their life expectancy is assessed to be 6 months or less. The goal is to ease the transition and minimize suffering.[24] Hospice services generally include medical equipment and supplies. The focus is on symptom management and psychosocial support. The hospice team includes physicians, nurses, social workers, therapists, and counselors.

Patients continuing dialysis are generally not accepted to hospice for financial reasons (the hospice program would have to bear the costs of dialysis) unless they also have a non-ESRD terminal diagnosis. However, if the patient has a terminal diagnosis other than ESRD, payment for dialysis may be covered under the ESRD Medicare Program, and the patient can be enrolled in hospice under Medicare coverage for the terminal diagnosis. Despite potential benefits to the patient and family, hospice enrollment is quite low (42%) even in patients who withdraw from dialysis.[25] This is unfortunate because hospice provides excellent comfort care at the end of life and has also been proven to be more cost-effective than traditional care.[26] Steps proposed to correct this issue include better education of medical practitioners and early advanced care planning.[24,25] Providing hospice care for patients who wish to remain on dialysis is also receiving support.[20]

Non-Initiation of Dialysis is not the Same as Withdrawal From Dialysis

Another point to consider is how withdrawal of dialysis is different from non-initiation.[19] Patients who are managed conservatively without initiating dialysis may live for months or quite possibly years. Patients withdrawing