EDITORIAL

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The Future of Palliative Care in Nephrology

Cristina Outerelo[1], Ana Mateus[2]

[1] Division of Nephrology and Renal Transplantation, Department of Medicine, Centro Hospitalar Universitário Lisboa Norte, Lisbon, Portugal
[2] Division of Nephrology and Renal Transplantation, Hospital Cruz Vermelha, Lisbon, Portugal

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In recent years, the number of patients with end-stage kidney disease (ESKD), most of whom are elderly and have multiple comorbidities requiring complex medical care, has increased significantly. As a consequence, there might be a need to improve the quality of care for patients with ESKD who are nearing the end of life, and conservative care should no longer be out of the question. Before the advent of chronic dialysis, no option was the only option, and care was directed to minimize suffering in end-of-life. When hemodialysis became possible to treat patients with ESKD, intense efforts to select the patients that would benefit the most were the rule. As the technique became widespread, older and more frail patients were also admitted, because there are still few absolute contra-indications for hemodialysis. Progresses in peritoneal dialysis technique allowed growing of programs all over the world. Kidney transplant grew in parallel with these options, becoming the best approach to treat chronic kidney disease and its complications, for those that were eligible.

However, we soon realized that mortality of ESKD patients had reached an invariable point. As older, sicker and more frail patients were started on dialysis, it was becoming obvious that survival may not be the hard outcome we are looking for in this subset of patients. Still, death as an expected part of life is trivially acknowledged by all but rejected by many. Conservative care views death as a natural process and provides individualized care to patients in the last phase of their life, while respecting their values, beliefs, culture and religion. The principles of this approach rely in shared-decision making processes, advance care planning and symptom control, aligning the interventions with the patients´ goals of care and improving their quality of life.[1] Accordingly, conservative care programs started emerging internationally.

The importance of quality of life (QoL) is becoming prominent in all ages and areas of our society, and ESKD patients are no exception.[2] The question of whether we prefer a longer life with worse QoL than a shorter and better one is still a paradigm with no correct answer. Efforts are made to statistically prove that in certain patients, QoL is reduced after starting dialysis, albeit their life may be prolonged.[3,4] However, if the patient can actively choose after a precise and informed decision-making process not to start any form of dialysis, it could represent an advantage in terms of QoL, even if their life span is shortened.[5]

Nevertheless, the decision itself is not based solely on quantity or even quality. Quality of life is extremely difficult to quantify, especially in patients with cognitive impairment. Conservative care in Nephrology should therefore not be seen solely as the QoL option in the individual patient with ESKD. Conservative care must be an option offered to the suitable patient, and is becoming increasingly chosen as nephrologists and patients are aware that there is an alternative that permits establishing an individualized plan respecting the patients´ priorities.

Despite the potential benefits of conservative care in advanced chronic kidney disease, nephrologists face several obstacles. Nephrologists are tasked with making complex decisions about who is eligible for dialysis and coordinating ongoing care.[6] Palliative care is not currently part of the nephrology curriculum, and many nephrologists do not feel equipped with the knowledge and skills to provide conservative care for patients for whom dialysis is not an option.[7] To complicate more, our palliative care network is not developed and lacks strength and coverage throughout the country, with different regions facing different problems in access to the network.

For conservative care to be an option that patients can actually choose, nephrologists must work together on behalf of their patients. Conservative care programs must be implemented, investment in education should be a priority and palliative care cannot be seen as the last resource. Health care providers also need more education and practice to talk about end of life at the right time and in the right way, engaging the patient and caregivers in the shared decision-making process.[8] Principles of conservative care must be applied, evaluations must be done, in order to stratify and aid in decision making, whether in prognostication, evaluation of frailty, comorbidities or cognitive impairment. Symptom burden must be identified and treated, and a plan must be designed that makes the patient, their family, the nephrologist and the other team members comfortable.[9]

Lastly, like other countries, Portugal maintains a national registry for patients receiving renal replacement therapy with dialysis

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and kidney transplantation. The comprehensive information that these registries provide on the incidence and prevalence of renal failure, as well as on the cost and quality of renal replacement therapy, exerts a strong influence on health policy. However, these registries do not collect data from patients in conservative care. This would promote an understanding of the use of health care resources and disparities in access to care, support the establishment of quality measures, and provide a step toward equitable renal failure treatment.

The future of palliative care in Nephrology therefore definitely relies on nephrologists, and steps are being taken worldwide to integrate conservative care in the management of chronic kidney disease patients. Our country is no exception, as we see a growing interest in this area and the development of programs in our Nephrology departments throughout the country reflecting our desire to improve care to our patients.

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Corresponding Author:
Cristina Outerelo
Division of Nephrology and Renal Transplantation, Department of Medicine
Centro Hospitalar Universitário Lisboa Norte
Av Prof Egas Moniz, 1649-028 Lisboa
E-mail: cristinaouterelo@gmail.com