

Palliative care for people with primary renal disease

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This talk will include:

- **Which patients?**
- **How many patients?**
- **What duration and course of illness?**
- **What palliative and supportive care needs?**

1. Which patients?

Which Stage 5 CKD patients?

- 1. Discontinuing dialysis**
- 2. Conservative management**

**Also: other palliative patients with
co-incident renal impairment**

2. How many patients?

End-stage renal disease (per million population) Renal Registries, 2006

	Incidence (pmp)	New pts /yr estimated	Existing pts estimated	Discont ~ 3-9% per annum	Conservative
UK	103	6,000	42,000	3,000	~15% - 7,500
USA	342	96,000	445,000	26,000	?

But...

- **Numbers of patients reaching ESRD increasing**
 - **Elderly**
 - **Co-morbidity**
 - **Poor functional status**

(USRDS report 2005, UK Renal Registry Report 2007)
- **% of UK deaths due to ESRD set to rise over the next 25 years (ONS 2000)**
 - **Epidemic of diabetes mellitus**
 - **Ageing population**
- **Numbers withdrawing from dialysis will increase**
- **More will be managed conservatively**

3. What duration and course of illness can

Dialysis discontinuation - duration?

- **Survival after dialysis withdrawal**
 - 8 to 10 days, range 1 - 46 days
- **Caution if residual renal function**

**Murtagh et al “Dialysis Discontinuation”
Advances in Chronic Kidney Diseases, 14 (4) 2007**

Conservative management – duration?

Age	Elam Median 80	Jassal 75+	Joly 80+	Lamping 70+	Murtagh 75+	Munshi 75+	Smith mean 71
N	69 C	3,672 D	107 D 37 C	123 D	52 D 77 C	58 D	26 C (pall non d)
1 yr surv- ival	69% C	69% D	76% D 30% C	71% D	84% D 68% C	53% D	21% C
From	eGFR <15	dialysis	index date (inc. late refs; often C)	dialysis	eGFR <15	dialysi s	putative dialysis initiation

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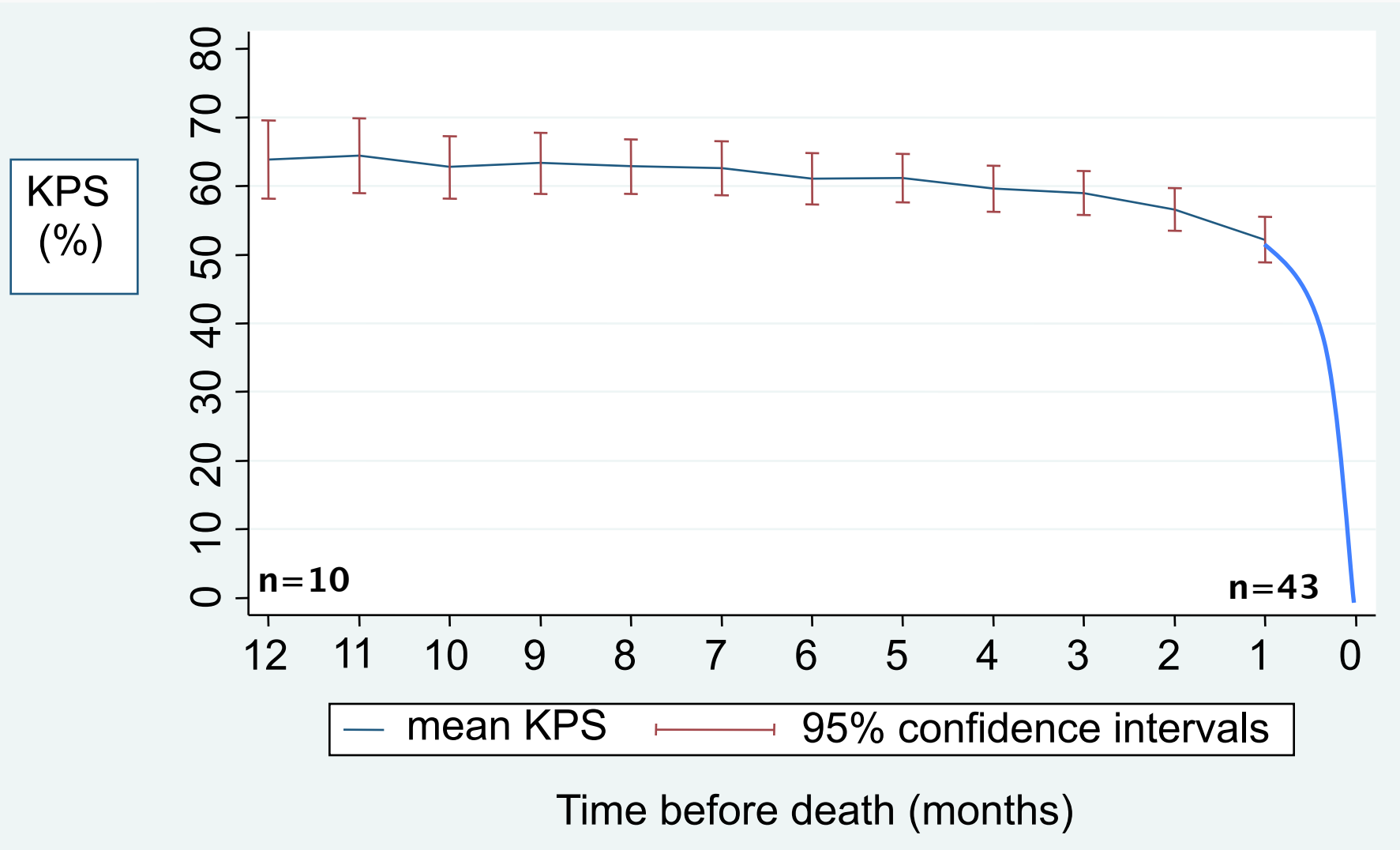
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What **course of illness
can these patients**

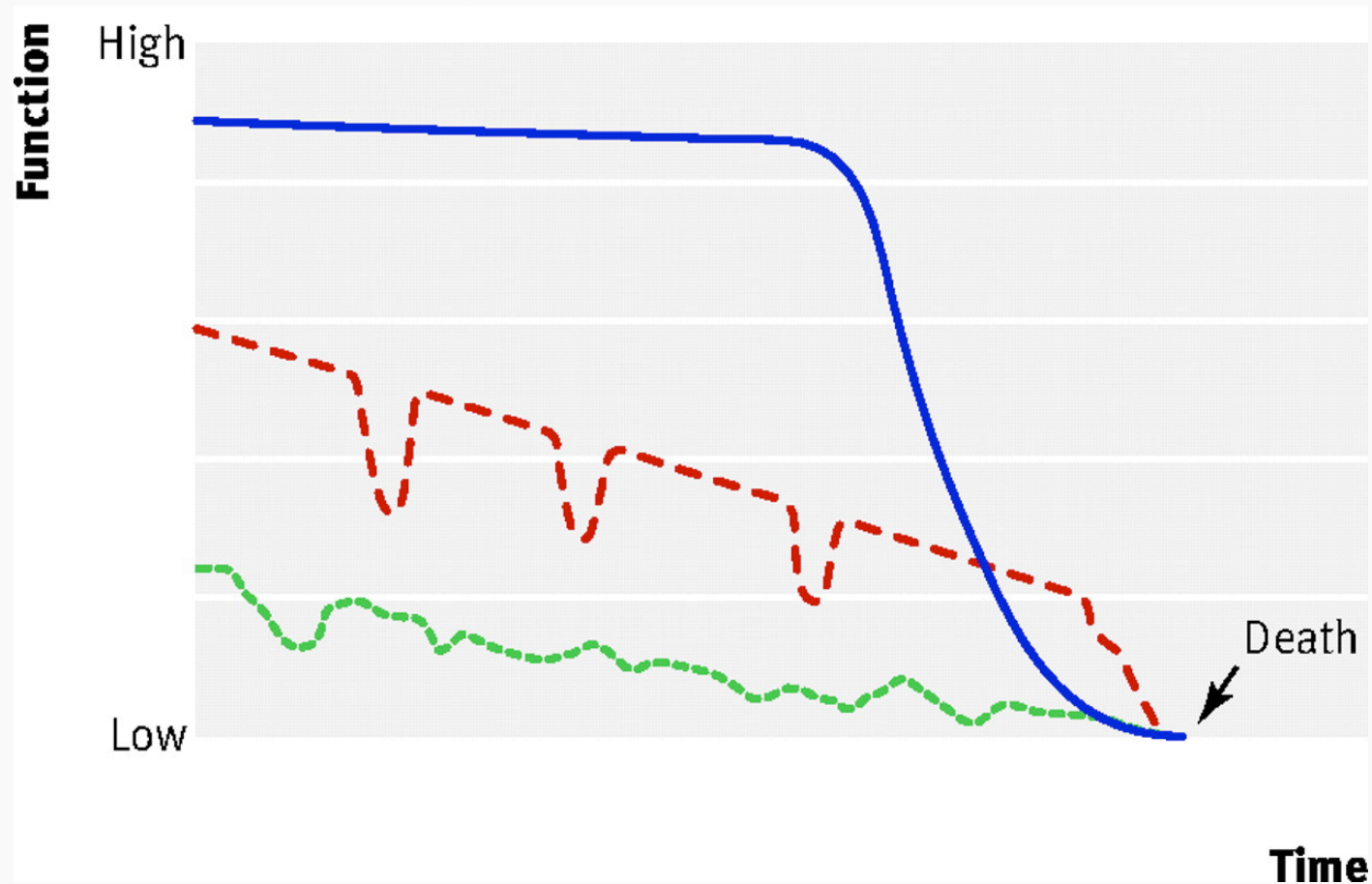
Longitudinal study of conservative stage 5 CKD

- **conservative (non dialysis) management**
- **N = 73 participants**
- **49 (66%) died during follow-up**
 - **mean age 81 years, range 58-95 yrs**
 - **24 (49%) men**
 - **median follow-up 8 months (range 1-23 months)**
- **Outcomes measured monthly until death or study end**

Trajectory of functional status:



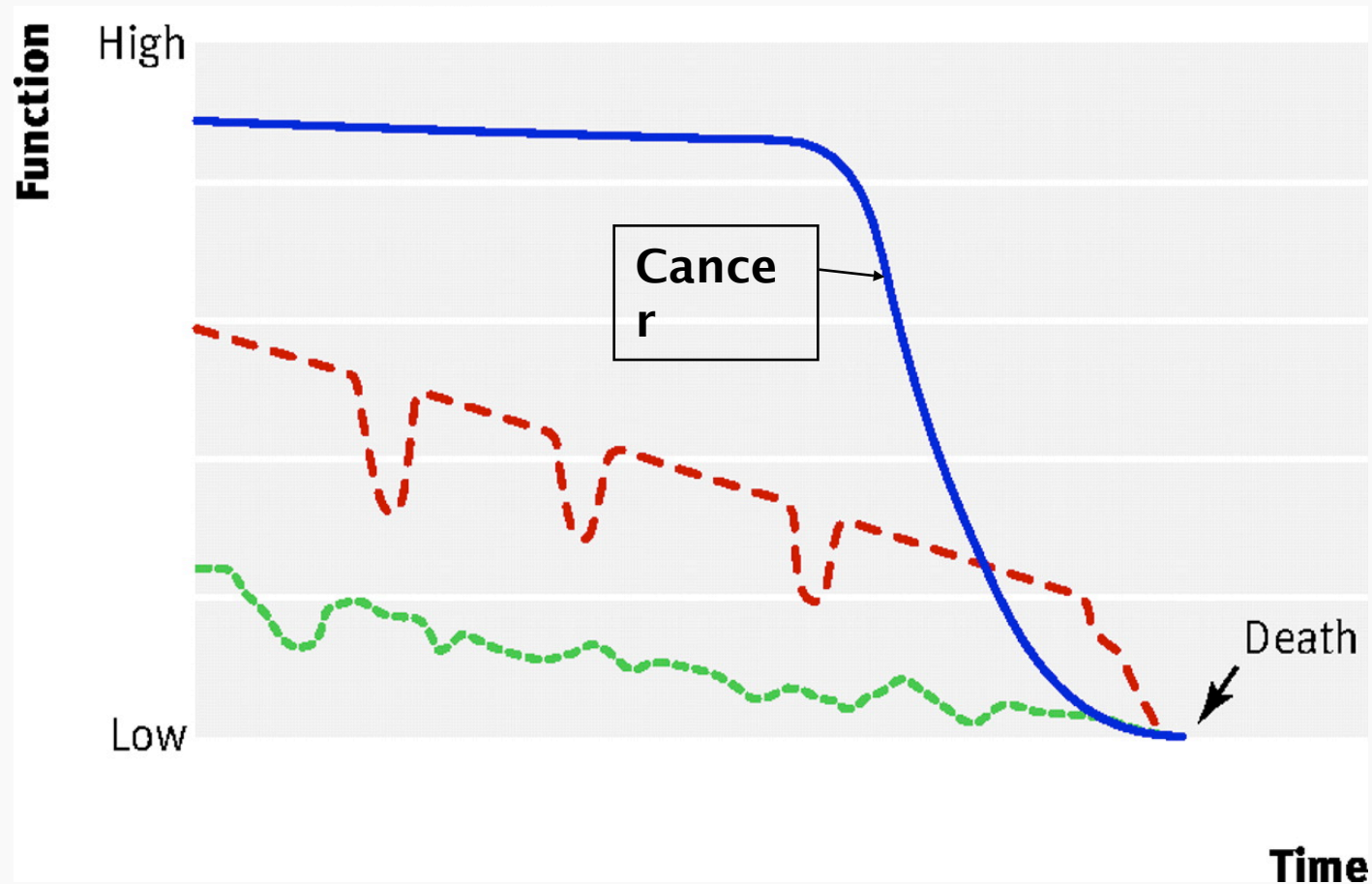
Trajectories of decline at the end of life



Murray, S. A et al. BMJ 2008;336:958-959

BMJ

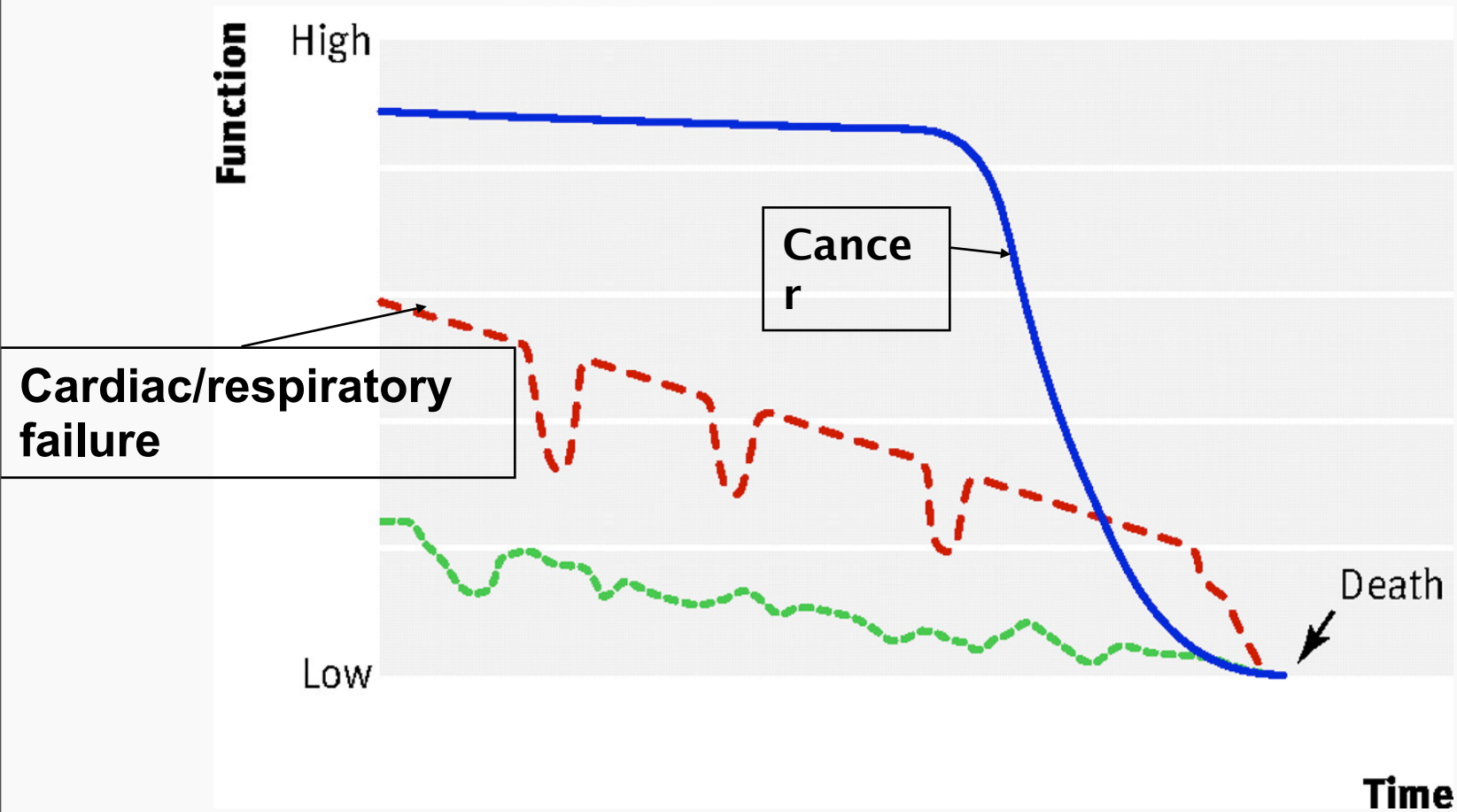
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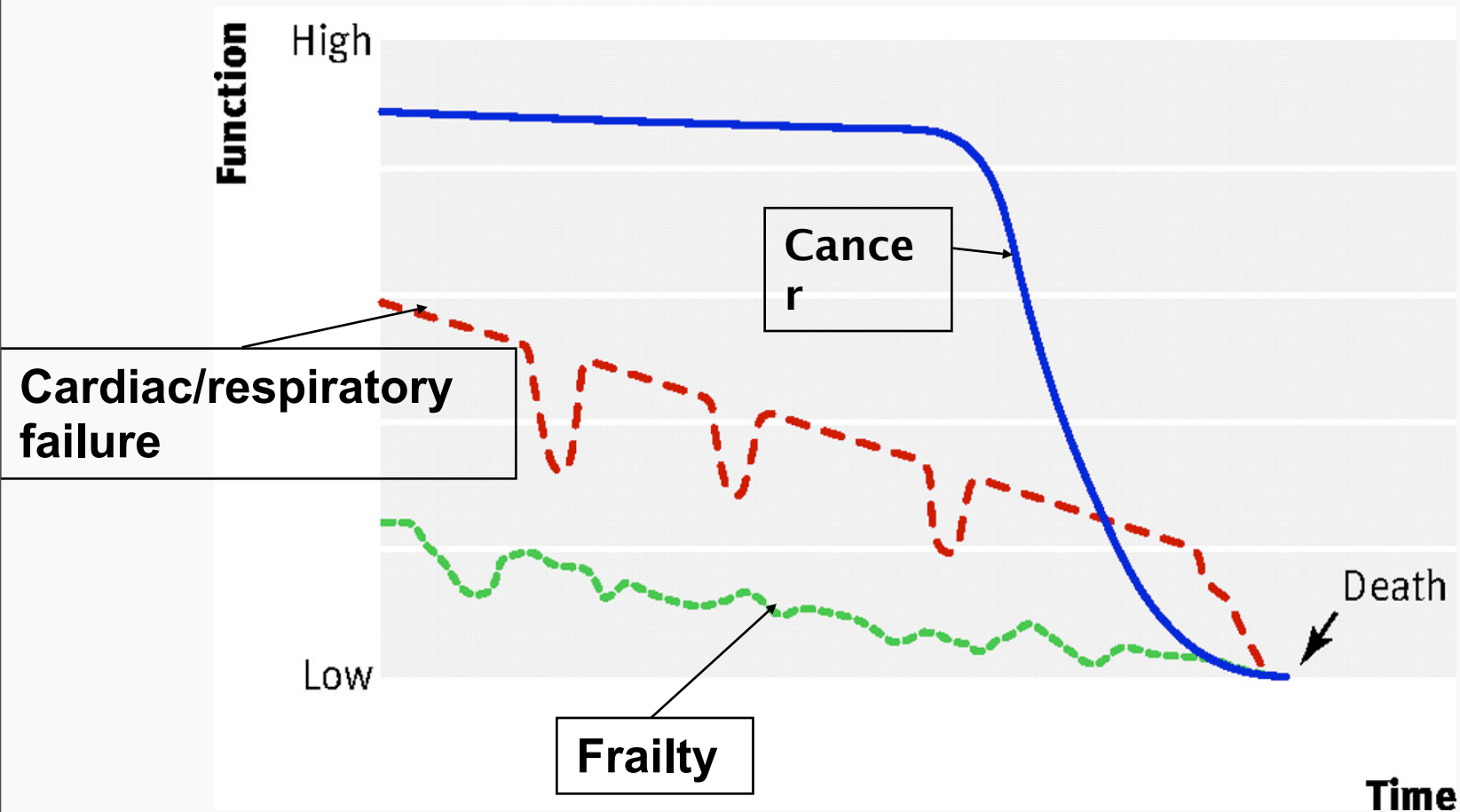
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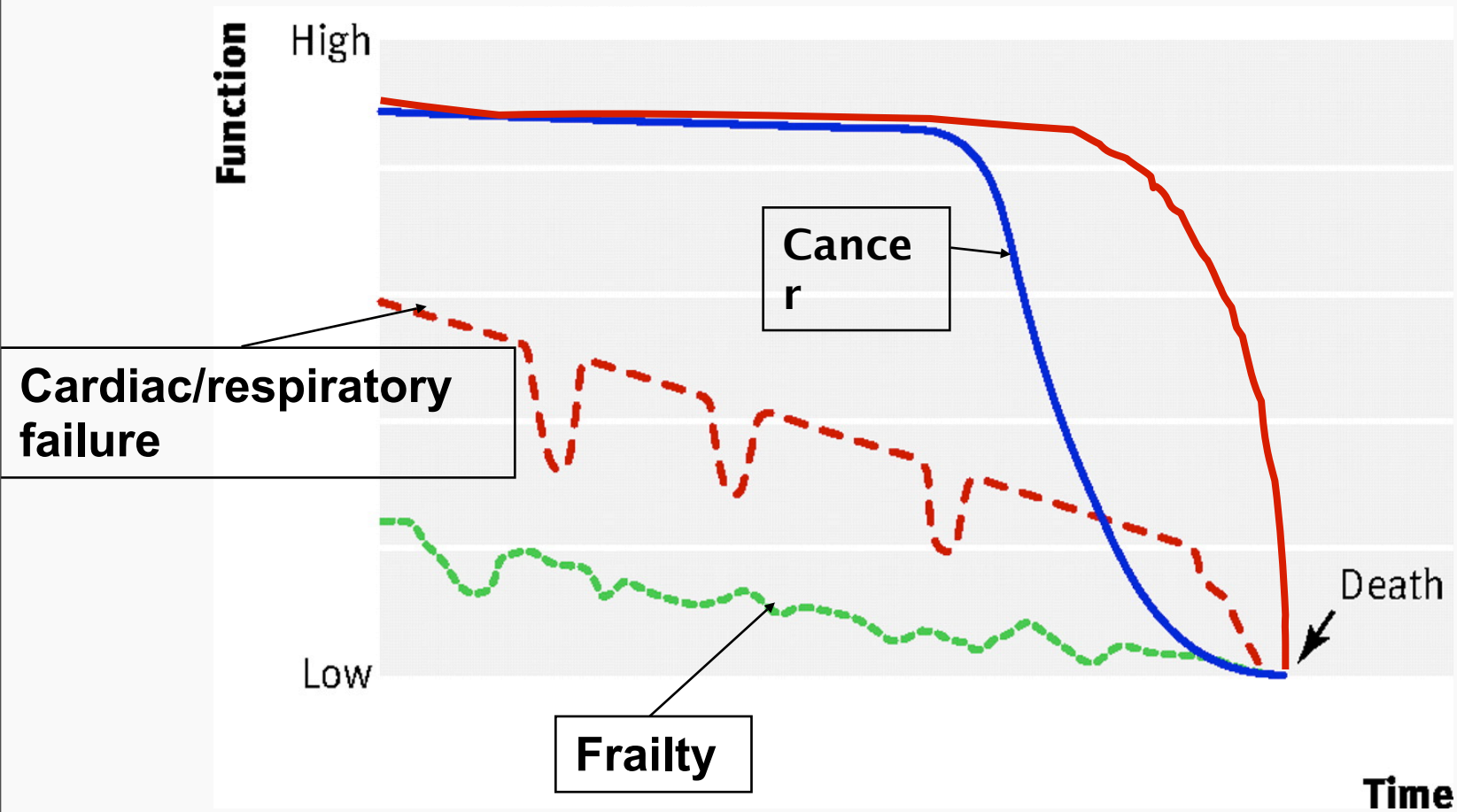
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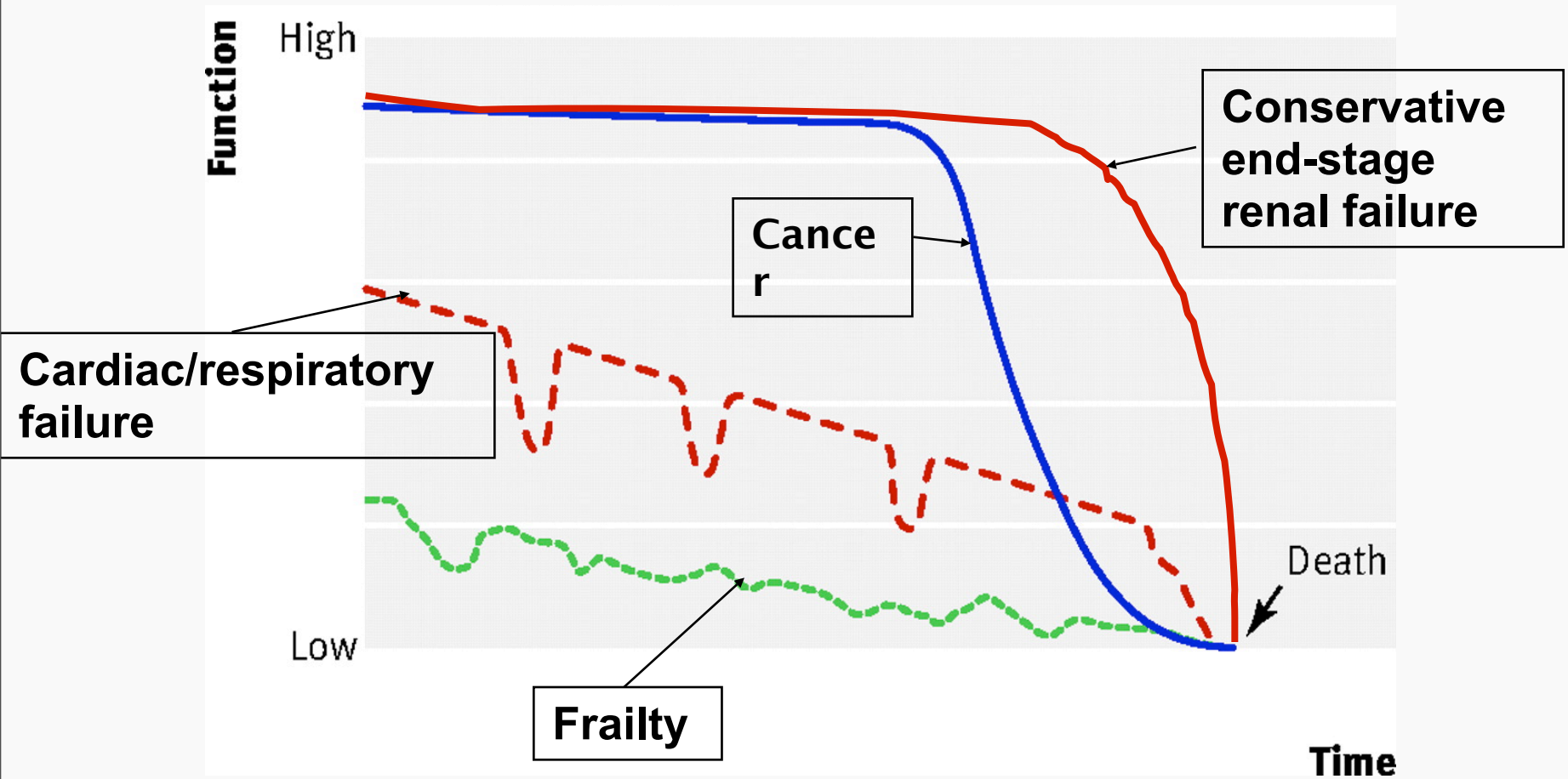
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4. What palliative and supportive care needs?

Palliative and supportive care needs

- **Symptom control**
- **Information and advance care planning**
- **Psychological needs**
- **Social and spiritual needs**
- **End of life care, including family support**

Comparison with other palliative populations

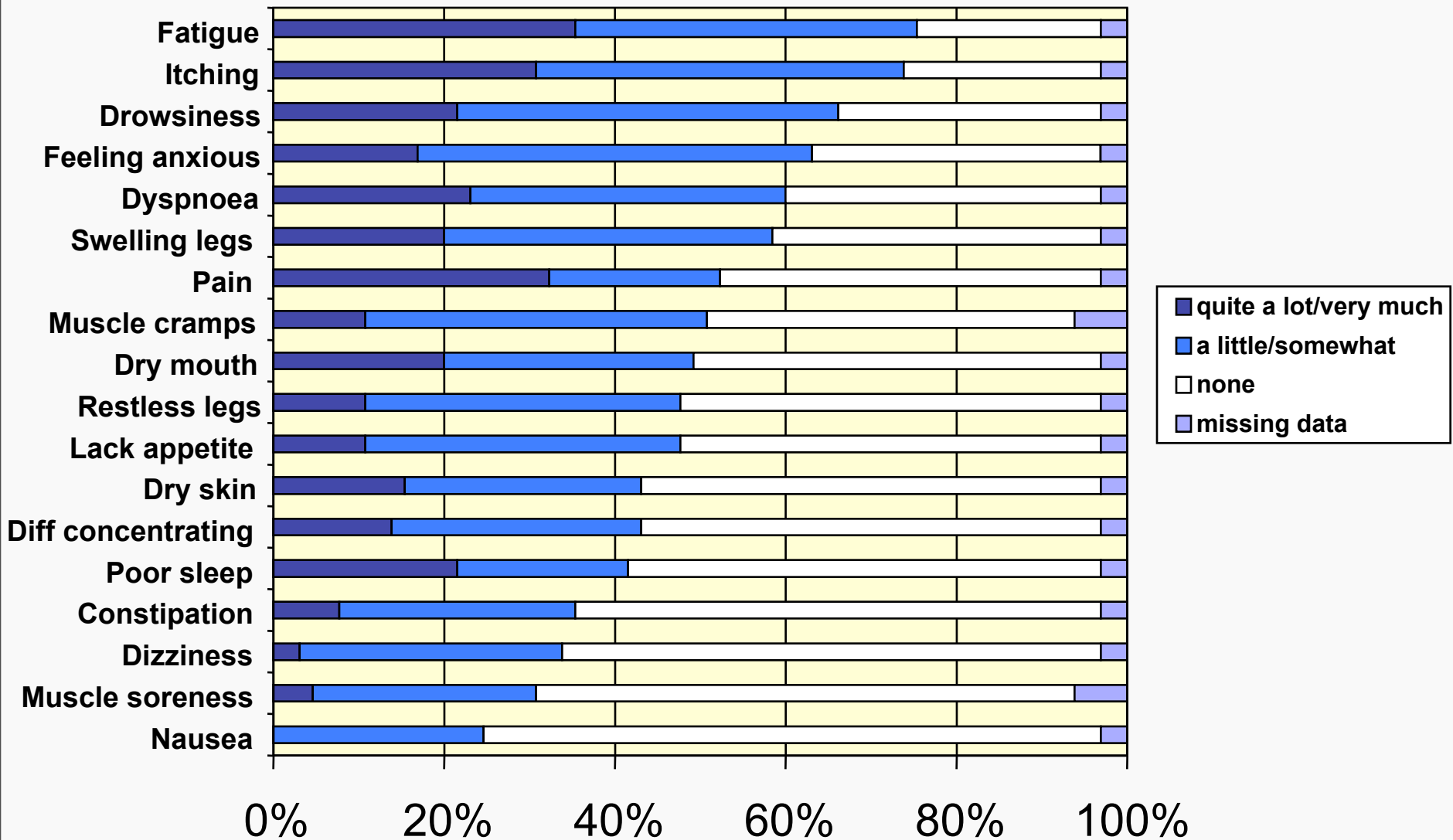
	ESRD on dialysis <i>Systematic review</i> own 2005	CANCER <i>Large multi- centre international study</i> Vainio et al 1995	CANCER & NON CANCER <i>Systematic review</i> - Franks et al 2000
Pruritus	55%		
Anorexia	49%	30%	37-66%
Pain	47%	57%	52-77%
Anxiety	38%		18-36%
Depression	27%		24-61%
Dyspnoea	35%	19%	20-69%
Nausea	33%	21%	16-54%
Sleep disturbance	44%	9%	19-88%
Vomiting	33%		20-27%
Restless legs	30%		

Stopping dialysis - symptoms?

(Prospective study of 131 patients. Cohen 2000)

	Present	Severe
Pain	42%	5%
Agitation	30%	12%
Myoclonu s	26%	14%
Dyspnoea	25%	3%
Nausea	13%	2%

Symptom prevalence (N=73)



Symptom burden

- **More than 1 in 3 patients had**
 - **lack of energy, pruritus, dyspnoea, pain, poor appetite, restless legs, poor sleep, constipation**
- **Mean number of symptoms was 12 with 3 added renal symptoms**
- **Renal-specific symptoms: itching, muscle cramps, restless legs**

Pain

- **Frequently unrecognised** (Davison 2003, 2007)
- **'75% of patients reporting moderate to very severe pain were not prescribed any analgesia'**
(Baillie et al 2004 DOPPS)
- **Often from co-morbid conditions:**
 - Ischaemic pain from peripheral vascular disease
 - Neuropathic pain from peripheral neuropathy
 - Bone pain from eg osteoporosis
 - Musculo-skeletal pain
 - Angina

(Davison 2003)

Symptom control challenging

- Symptoms often from co-morbidity
- ESRD constrains use of medication
- Use Cockcroft-Gault for drug dosing when $eGFR < 30$ (includes weight)
 - www.nephron.com/cgi-bin/CGSIdefault.cgi
- Review early and often - rapid accumulation and toxicity especially in stage 5 CKD without dialysis

Specific opioids:

- Alfentanil & methadone safe, reduce dose by 50%
- Fentanil may accumulate, reduce dose by 50%, caution esp in longer term use
- Buprenorphine theoretically a good choice, but little evidence
- Oxycodone little evidence, may be problematic in some individuals, reduce dose, increase dose interval
- Hydromorphone little evidence, may be problematic, reduce dose, increase dose interval
- Tramadol best step 2 but reduce dose & increase interval (max 50mg 12 hrly if eGFR < 30)
- **Avoid codeine, dihydrocodeine, morphine, diamorphine**

Renal management to reduce the effects of complications

- **BP control**
 - **Blood glucose control**
 - **Protein restriction**
 - **Hyperlipidaemia**
 - **ROD**
 - **Hyperkalaemia**
 - **Acidosis**
- **Fluid overload**
 - Salt and fluid restriction, diuretics, may need admission
 - **Vitamin D deficiency**
 - Symptomatic with weakness, muscle and bone pain
 - **Hyperphosphataemia**
 - may exacerbate pruritus
 - **Anaemia (Sx – fatigue and restless legs)**
 - Erythropoetin, iron

Conclusions

- **Numbers of ESRD patients needing palliative care are increasing**
- **These patients have considerable symptom and palliative care concerns, but considerable diversity**
- **Variable trajectory/palliative needs**
- **Flexibility and collaboration**
- **There is an urgent need for more evidence**

Thank you

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