Challenges in taking care of patients on chronic haemodialysis

Sir,

Dr Tozawa and his colleagues [1] bring out several interesting issues in their article on multiple medication use and increased mortality in chronic haemodialysis patients. Patients on a larger number of medications had multiple co-morbidities (i.e. type 2 diabetes, Table 1). This article, while accounting for the various illnesses, does not comment on the ‘severity of illness’ as it is likely that multiple medications could be used to manage any single chronic disease. A quality of life questionnaire could help in differentiating between the subsets of patients with the same disease who have an overall poorer perception of their health.

There remains, however, another aspect of the medical treatment which is gradually being recognized. Despite the awareness of evidenced-based guidelines on the management of diabetes mellitus, hypertension and preventive maintenance, physicians often fail to initiate appropriate treatment during patient encounters. This behaviour has been termed ‘clinical inertia’ [2].

Clinical inertia has been thought to be responsible for control of hypertension in only 45% of patients who are treated for hypertension [3] and achieving an adequate control of haemoglobin A1c of <7% (American Diabetes Association goal of control) in only 35% of patients treated for diabetes [4].

Among the main reasons for clinical inertia are physicians’ overestimation of the medical care which they provide, their hesitancy in avoiding intensification of medical therapy, and lack of training and practice organization focused on therapeutic goals [2].

Several recommendations have been made to avoid clinical inertia and they include: continued medical education emphasizing evidence-based guidelines, education programmes in undergraduate, graduate and postgraduate courses on clinical inertia, improved strategies that facilitate good care, use of computerized or paper flowsheets to follow tests, monitor therapy and initiate a change and also to implement routine preventive maintenance [2]. Regular feedback by peers on one’s performance has also been suggested as a useful strategy. It was encouraging to see that compliance with medication in the study under discussion was >60%, a much higher number than documented in the literature (~50%) [5].

Recent literature also indicates that the timing of referral to a nephrologist determines the prognosis of a patient with end-stage renal failure [6]. Late referral to a nephrologist (<4 months vs >12 months prior to initiation of dialysis) and severity of co-morbid disease were found to be important predictors for increased mortality. We do not have any information on the timing for referral to a nephrologist which could also account for the difference in mortality in the study [1].

Management of patients on chronic haemodialysis therefore requires not only constant surveillance of patient compliance with medication but also being aware of one’s clinical inertia, having a mechanism of self-improvement and receiving periodic routine reminders of one’s performance.

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DOI: 10.1093/ndt/gfg132