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Dialysis: when to start or when to stop?

Sir,

There have been several recent discussions around the timing of initiation of dialysis [1,2]. There remains little scientific consensus on when to start and on which clinical and biochemical parameters we base this decision. In the broadest sense, dialysis should serve to decrease morbidity and/or mortality whilst maintaining or improving quality of life. It is almost assumed that renal replacement therapy will offer this to all. However, an incident dialysis population is heterogeneous and failure to take this into account leads to non-individualized generic care. We must therefore recognize that the optimal time to start dialysis may differ for varied patient sub-groups. Additionally, in those individuals who fail to thrive on dialysis, then withdrawal of therapy has to be considered. This group may further provide insight into those individuals for whom dialysis is altogether inappropriate. These questions are perhaps posed most often when we consider an elderly co-morbid patient with end-stage renal failure (ESRF). Following the introduction of dialysis it has been demonstrated that age correlates with symptom burden on renal replacement therapy [3]. UK Registry data reports a 50% mortality at 1 year in incident dialysis patients over the age of 85 years, with the greatest attrition rate being in the first 3 months [4]. This early mortality may negate any subsequent benefits from an early start. Furthermore, Williams et al. [5] examined 24 consecutive cases in which dialysis was felt to be inappropriate. It was found that even when a conservative approach is taken functional status could be maintained until death is imminent. The following short cases highlight the points that an 'early start' may not lead to maintenance, but to deterioration in quality of life. Also, that dialysis can be withdrawn in some with the realistic expectation of an improvement in symptoms and with the preservation of independence making it a viable therapeutic option.

Case 1. An 83-year-old female with ESRF (calculated GFR of 7 ml/min) secondary to renal limited vasculitis commenced haemodialysis (HD) via a native fistula. She achieved a urea reduction ratio (URR) in excess of 65%. Although no haemodynamic compromise occurred, HD left her severely fatigued. Consequently she spent the inter-dialy tic interval hospitalized and nursing dependent. Following discussions with the patient, HD was discontinued 5 months after initiation. All other medical therapies were continued. She remains at home 1 year after discontinuation.

Case 2. An 81-year-old male with ESRF (calculated GFR of 13 ml/min) secondary to diabetic nephropathy commenced HD via a native fistula. Despite several modifications to his HD prescription he suffered recurrent haemodynamic collapse and paroxysms of atrial fibrillation. Following discussion, treatment was withdrawn 10 months after initiation. With adherence to fluid and dietary restrictions he has required no hospitalizations in the following 7 months.

Case 3. A 78-year-old female with severe cardiac compromise and ESRF (calculated GFR of 8 ml/min) secondary to diabetic nephropathy commenced HD via a cuffed catheter. She achieved a URR of > 65%. Again, HD left her severely fatigued and following 2 months of hospitalisation she discontinued dialysis. She required no further hospital admissions before her death 6 months after discontinuation of HD.

Dialysis is no longer restricted to certain populations. We may be guilty of extrapolating benefit into individuals where this may not be the case. Indeed it is conceivable that in some we may cause harm. Any further work into the timing of initiation of dialysis should take into account the heterogeneous nature of the ESRF population and should be extended to cover the other issues raised here, as they are relevant to daily clinical practice.

Conflict of interest statement. None declared.

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Severe ascites following renal transplant biopsy caused by a rupture of a subcapsular lymphocele: treated successfully by retroperitonealization

Sir,

We would like to share our experience of a patient who developed subcapsular lymphocele post cadaver transplant from a paediatric patient. Lymphoceles complicate 18% of renal transplants [1]. They usually occur in the first 6 months following transplant [2]. Lymphoceles are usually diagnosed because of pain over the transplanted kidney, or are found incidentally during investigation of renal failure. They may cause ureteric obstruction [3]. Many treatment regimes have...


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