Introduction and Aims: Elderly patients reaching ESRD is a growing population with several therapeutic options such as RRT or conservative care. The evolution about therapeutic projects in this elderly population is not well documented and prospective cohorts studies are needed to better understand how this decision may change during the period of advanced CKD.

Methods: The PSPA study is a French multicenter prospective cohort study that describes the care of elderly patient (>75yrs) reaching ESRD (eGFR<20 at inclusion) [Moranne, J Gerontol, 2012]. The therapeutic project was declared at inclusion in the cohort and re-evaluated at each visit during the follow-up, according to possible changes of nephrologists’ or patients’ opinion. These therapeutic projects options were as follow: (1) ongoing evaluation of the patients’ clinical condition (EV AL); (2) postponed decision about dialysis due to a stable eGFR (STABLE); (3) decision has been made to start dialysis when required (DIAL); (4) non-dialysis decision at nephrologist (NDne) or (5) patient request (NDpt). The 4 year outcome was recorded for the entire cohort. The trajectory of the therapeutic options was defined as unchanged if the declared project stayed the same from inclusion to outcome (death, dialysis start or last follow-up) and composite if several options were declared during follow-up. The incidence of dialysis start or death was analyzed according to these trajectories.

Results: 574 patients were studied. At inclusion population age was 82 ± 5 yrs., 57% were male, 40% had diabetes and the median eGFR was 14 [11;17] mL/min/1.73m². At inclusion the therapeutic project declared was: DIAL=128 [22%], NDne=48 [8%], NDpt=44 [7.5%], STABLE=251 [44%], EV AL=103 [18%]. During follow-up unchanged therapeutic projects since inclusion concerned 336 patients (58%): 94% for DIAL option, 89% for NDne, 72% for NDpt, 45% for STABLE and 27% for EV AL. After excluding possible STABLE and EV AL options periods during the follow-up, we identified 3 composite projects in 46 patients: DIAL-NDpt=27 [5%], DIAL-NDne=7 [1%], NDne-NDpt=12 [2%]. The NDne option increased during follow-up (8 to 13%) as well as the NDpt (7.5 to 10%). During follow-up most of the DIAL patients started dialysis (86%) while 7% died. None of the NDne patient started dialysis while 11% of the NDpt patients did. Respectively, 96% and 70% of those patients died without dialysis. Patients with composite project such as DIAL-NDpt started dialysis (67% vs 19% death) and DIAL-NDne patients mostly died before dialysis (86% vs 14% dialysis start). Few patients with NDne-NDpt started dialysis during follow-up (1% while 75% died). Respectively 50% and 57% of the unchanged STABLE and EV AL patients died before dialysis while 18% and 21% started dialysis.

Conclusions: In this cohort of elderly reaching ESRD, we observed an evolution of the share decision therapeutic option for 42% of the patients. The observed composite projects DIAL-NDne, DIAL-NDpt represented few patients in our cohort (6%) but highlights the complexity of therapeutic projects’ evolution. Those various trajectories are associated with various outcomes and imply a specific care organisation of the share decision making process. Associations between these trajectories with initial conditions at dialysis initiation and early prognosis in dialysis need to be evaluated more deeply.