THE PLACE OF PALLIATIVE CARE-RELATED HOSPITALIZATION IN THE MANAGEMENT OF END-STAGE RENAL DISEASE PATIENTS ON RENAL REPLACEMENT THERAPY IN FRANCE

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Introduction and Aims: Palliative care is seldom proposed to patients with end-stage renal disease despite a mortality rate and disease burden as high as among cancer patients. In the US, 13.5% of the deceased patients on dialysis used hospice; even among patients who withdrew from dialysis, whose death is usually certain, only 42% of them use hospice. To our knowledge, the access of dialysis patients to palliative care has never been quantified in Europe. The aim of this study is therefore to analyze the place that palliative care-related hospitalization occupies in the management of ESRD patients on dialysis in France, by describing the characteristics of these hospitalizations, the clinical status of the concerned patients, and the use of palliative care in those stopping dialysis.

Methods: The French REIN registry includes data about 51,834 patients aged 20 years and older who began dialysis from January 1, 2008, to December 31, 2013, and were followed longitudinally until that date. Linkage to the anonymized national hospital discharge database allowed us to analyze hospitalizations associated with palliative care.

Results: During the follow-up period, there were 17,168 deaths in the total cohort (33% of the patients), and 1865 patients (3.6%) had a palliative care-related hospitalization corresponding to a total of 3382 hospitalizations. Lower levels of serum albumin, active cancer, and impaired mobility were each independently associated with the probability of at least one such hospitalization. During the same period 4540 patients withdrew from dialysis (9% of the patients), 10% of them had a palliative care-related hospitalization. Among the patients who withdrew from dialysis, referral to palliative care tended to be higher in those who were younger, while among those continuing dialysis, this rate was higher among those who were older.

Conclusions: In conclusion, this study shows low access to palliative care-related hospitalization for ESRD patients, even those withdrawing from dialysis (a situation in which death is expected and predictable) and suggests that this access differs according to comorbidities. In light of these findings, cooperation between nephrologists and physicians trained in palliative care should be improved at least to the extent necessary to identify patients who should be referred to palliative care. Training practitioners and dialysis staff in palliative care, assisted by a mobile palliative care team, as well as dedicated palliative beds in each nephrology unit may be an attractive option and offers the advantage of preserving the meaningful ties between patients and nephrology staff.

Committees for ethics in nephrology, through multidisciplinary deliberations and conflict resolution process, aims to propose an ethical shared-decision-making model ensuring that dialysis withdrawal occurs according to professional guidelines. Further studies are needed to evaluate the benefit of specific palliative care in this population versus supportive care given by the nephrology team. Our study also highlights the need of more information on the current access to any kind of supportive care for dialysis patients.