

2014

Renal Supportive Care – an overview.  
Frank Brennan, Palliative Care Physician.

# Renal Palliative Care – Caring for adult patients with ESKD – an overview

Frank Brennan  
Palliative Care Consultant  
Department of Nephrology  
St George Hospital Sydney, Australia

British Columbia Kidney Days, Vancouver, British Columbia, Canada  
October 2014

A 53 year old woman

- Type 2 Diabetes Mellitus
- Hypertension
- OA – mild
- ESKD – Diabetic Nephropathy
- HD 3/week for 5 years

- Shuffled in to the clinic room
- Head down
- No eye contact

“My legs move all through the night” –  
Severe Restless Legs Syndrome - 2  
years

“I itch all the time... often it becomes ferocious”  
Severe uraemic pruritus – 3 years

“My feet and calves burn and get pins and needles – it is awful”

Severe diabetic peripheral neuropathy – 18 months

And sleep ?



“I don’t sleep... I doze in 5 minute lots...

“I sit on a chair and put my elbows on my knees to hold them still...

and I pray to die.”

# Overview

What is Palliative Care ?

What role does Palliative Care have in Nephrology ?

Withholding and withdrawing from dialysis

What exactly is the conservative, non-dialytic management of ESKD ?

Symptom management

# Care of the dying patient with ESKD

Creating and nurturing a Renal Supportive Care service



**What is Palliative Care ?**



## **WHO definition (2002)**

**Palliative Care is an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.**



## **Myths**

**There is virtually no common ground for active treatment of disease and palliative care.**

# Myths

That palliative care is simply the care of the dying

# Myths

That palliative care means giving up hope

# Modern view of Palliative Medicine

A. Early involvement : “There is wide recognition that the principles of palliative care should be applied as early as possible in the course of any chronic, ultimately fatal illness.”



B. The concept of concurrent care : that active care and palliative care can and should occur together.

c. That bringing in a palliative approach as the person is dying is a set of missed opportunities.

## **Benefits of early involvement–**

- reinforcement of idea of comfort.**
- that symptom control is impeccable throughout.**
- establishing a rapport/trust**
- demystifying analgesia (opioids)**
- introducing idea of Community Care**
- helps avoid sense of abandonment**

D. That palliative care can be applied to all life-limiting illnesses

**What possible role does Palliative Care play in End Stage Kidney Disease ?**

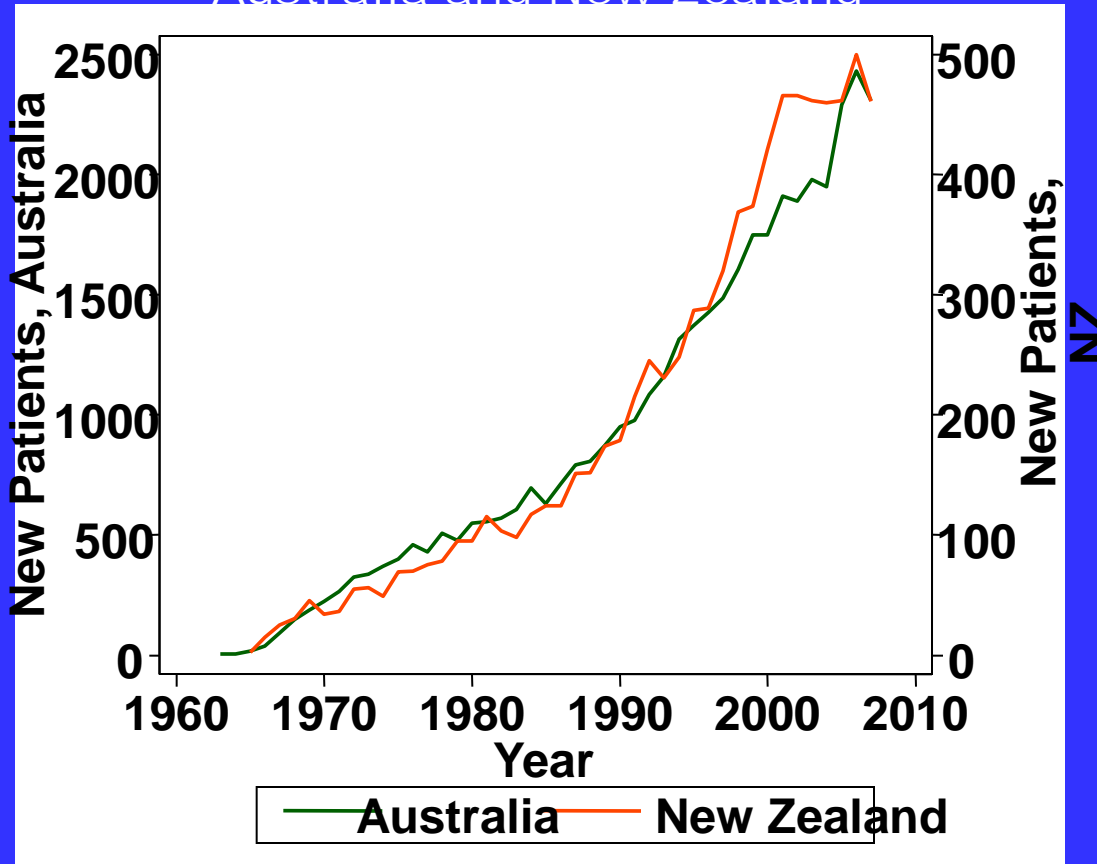
# 1. Epidemiology

# DIALYSIS PATIENTS

In developed nations the characteristics of patients on dialysis have changed over the years.

Essentially more elderly patients with co-morbidities.

# Number Starting Renal Replacement Therapy Dialysis or Transplantation Australia and New Zealand





In western nations the mean age of commencement on Renal Replacement Therapy is 60 - 65 years.

Increasing number of patients returning to dialysis after transplant failure.

The age cohort that has the greatest prevalence is the 65-84 year old group.

Canadian Organ Replacement Register (CORR) Report 2014

The other aspect of this change which will be a rising challenge globally is the rise of  
Diabetes Mellitus

# In Canada - Prevalent ESKD by primary diagnosis

Diabetes – 27.1 %

CORR Report 2014

Does everyone who has ESKD commence dialysis ?

In Australia, for every one patient with  
ESKD receiving Renal Replacement  
Therapy (RRT)

there is another who does not receive  
RRT

Australian Institute of Health and Welfare Research,  
2011

## 2. Mortality

# ESRD patients

Overall patients with ESKD with or without RRT have a reduced life expectancy compared to age-matched controls.



# DIALYSIS

For patients on dialysis 15.7 % die each year (CORR Report 2014)

For those aged 75 years and older that figure is 25 %

(CORR Report 2014)

### 3. Symptomatology

Patients with ESKD have a significant symptom burden related to both the disease itself and other co-morbidities

What are the common symptoms associated with ESKD ?

# The Prevalence of Symptoms in End-stage Renal Disease : A systematic Review

Murtagh FE et al. *Advances in Chronic Kidney Disease* Vol 14, No 1  
(January) 2007; pp 82-99

# A Cross-sectional Survey of Symptom Prevalence in Stage 5 CKD managed without Dialysis

Murtagh FEM et al. J Pall Med (2007) 10;6:1266-1276

# SYMPTOM PREVALENCE

Dialysis

Conservative

	Dialysis	Conservative
FATIGUE/TIREDNESS	71%	75%
PRURITUS	55%	74%
CONSTIPATION	53%	
ANOREXIA	49%	47%
PAIN	47%	53%
SLEEP DISTURBANCE	44%	42%



# SYMPTOM PREVALENCE

Dialysis

Conservative

	Dialysis	Conservative
ANXIETY	38 %	
DYSPNEA	35 %	61 %
NAUSEA	33 %	
RESTLESS LEGS	30 %	48 %
DEPRESSION	27 %	

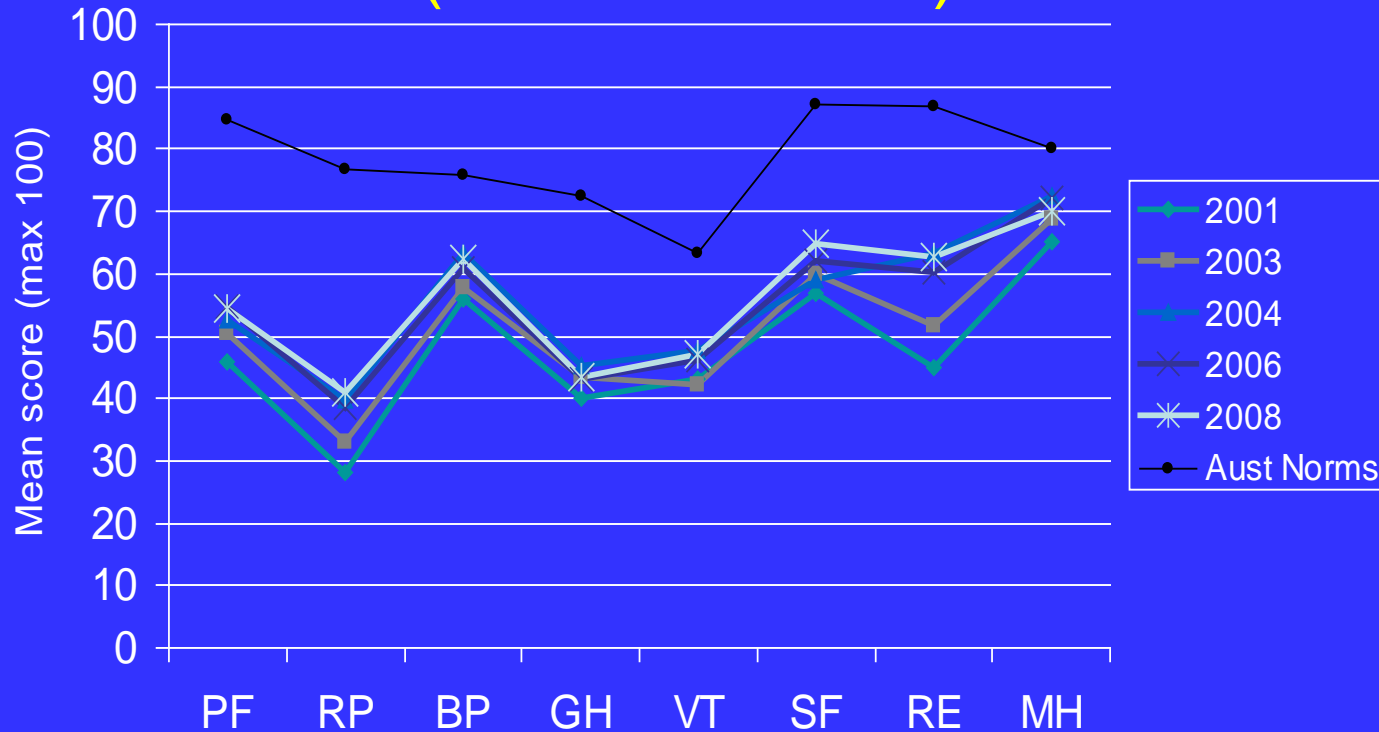
- Symptoms are prevalent
- Symptoms are multiple
- Symptoms are burdensome

The management of symptoms are challenging

with the altered pharmacokinetics of most medications in renal impairment

## 4. Quality of life

# QOL - St George dialysis (SF-36 Scores)



## 5. The “quality” of dying

Realistically, given issues of manpower,  
it may not be possible for a Palliative Care health  
professional to be present in every  
Renal Unit

What are the core competencies in a “Palliative approach” to patients with ESKD for medical practitioners ?



# 4 Pillars of a Palliative approach

- Communication
- Symptom management
- Psychosocial support
- Care of the dying patient

**Communication**

Once ESRD is diagnosed it is important examine the various options

RRT

Conservative

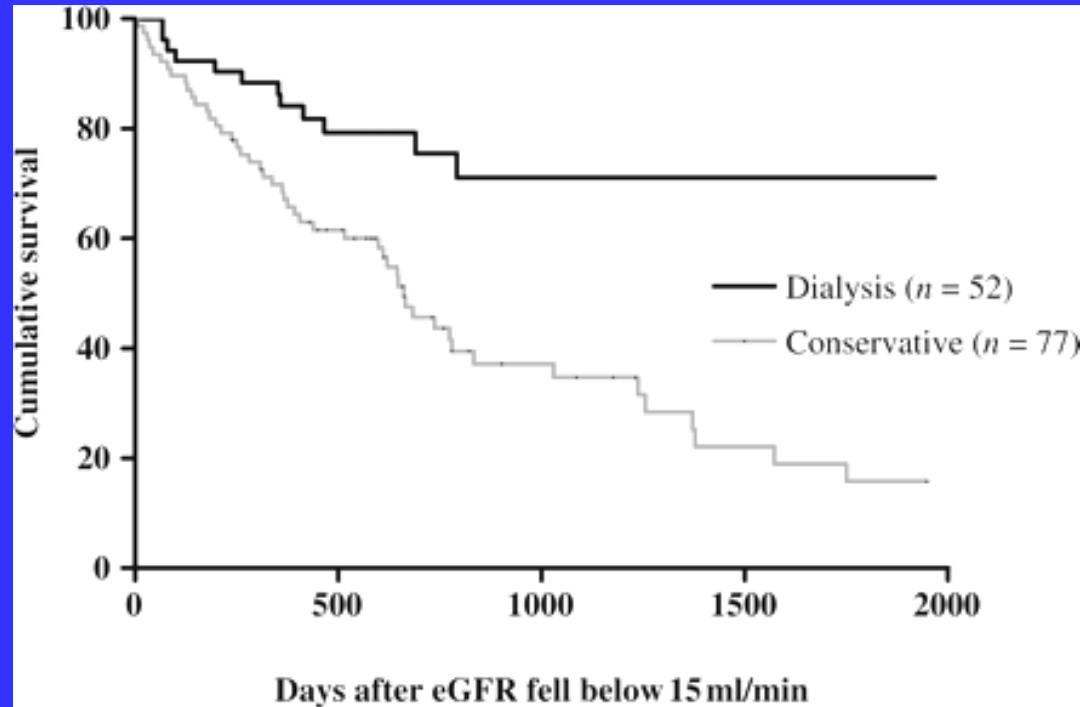
# Decision making around dialysis

Survival

Dialysis or not ? A comparative study of survival of patients over 75 years with CKD Stage 5.

Murtagh FEM et al. *Nephrol Dial Transplant* 2007;22:1955-1962

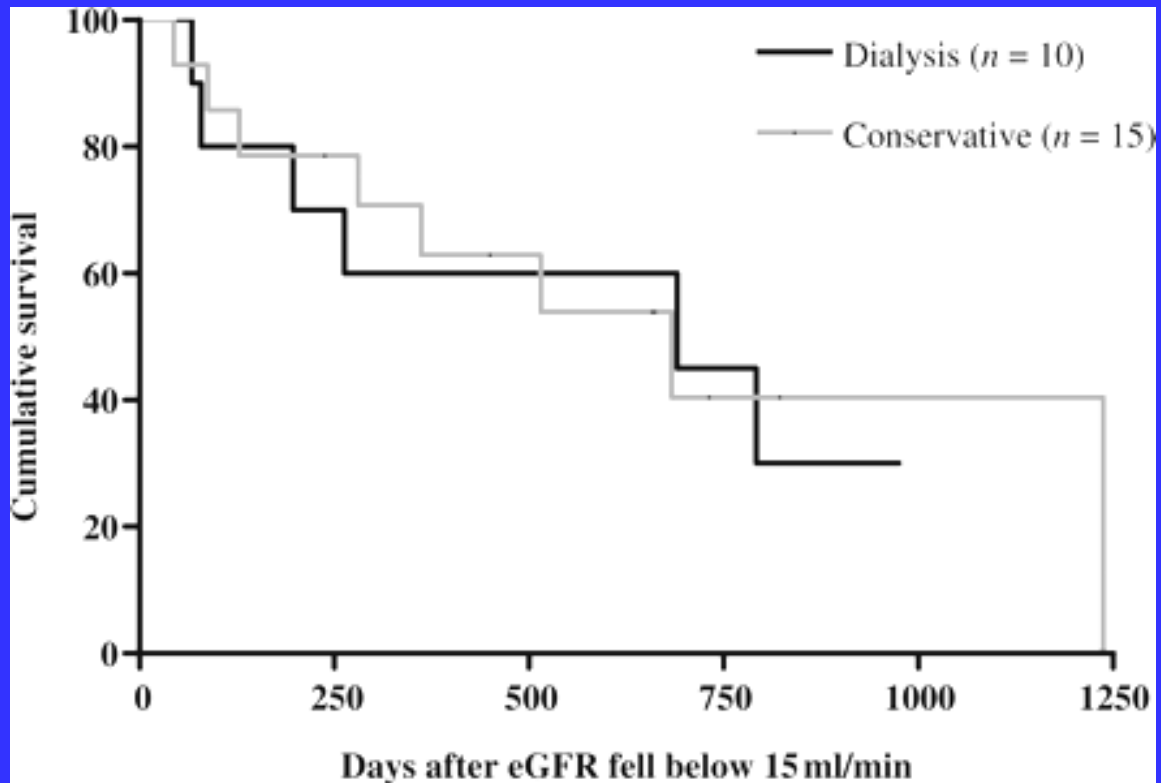
# Survival



Murtagh et al. NDT. 2007;22:1955-62

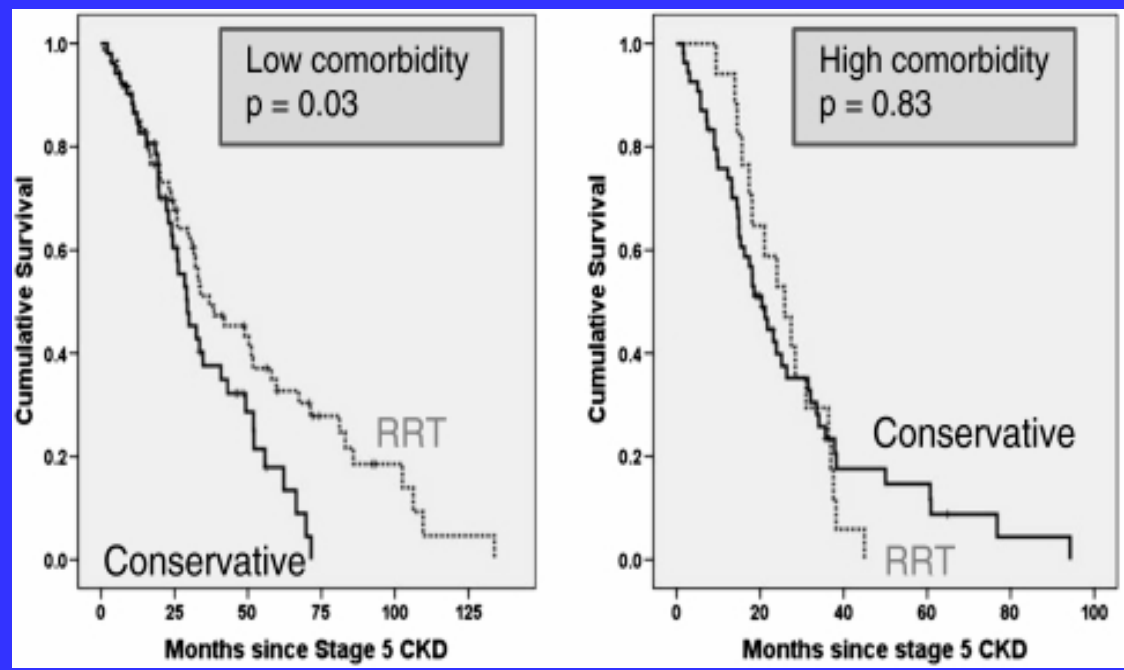


## Survival benefit lost if Co-morbidities include IHD



# RRT v Conservative

Chandra et al NDT Nov 2010



# Dialysis in Frail Elders — A Role for Palliative Care

*Robert M. Arnold, M.D., and Mark L. Zeidel, M.D.*



The NEW ENGLAND  
JOURNAL of MEDICINE

Volume 361:1597-  
1598

October 15,  
2009

## Change in Functional Status after Initiation of Dialysis

3702 Nursing home residents mean age 73

Mean eGFR 10

Female 60%

Diabetes 68%

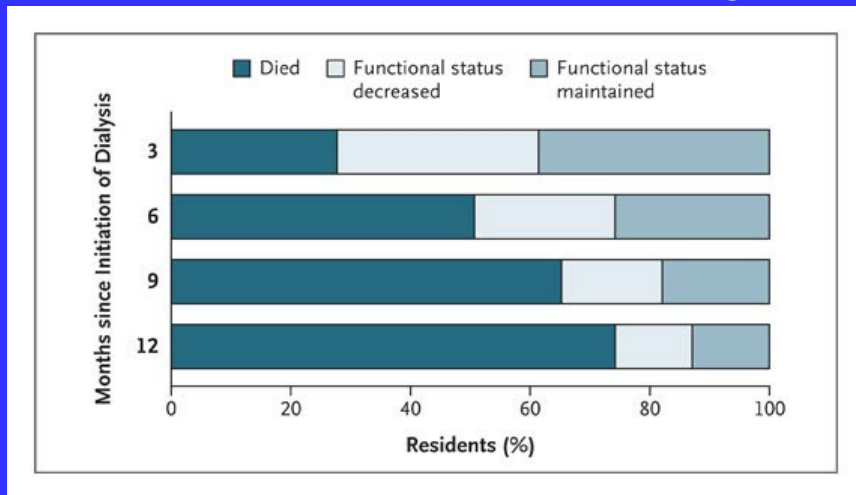
CHF 66%

CHD 44%

Cerebrovascular dis. 39%

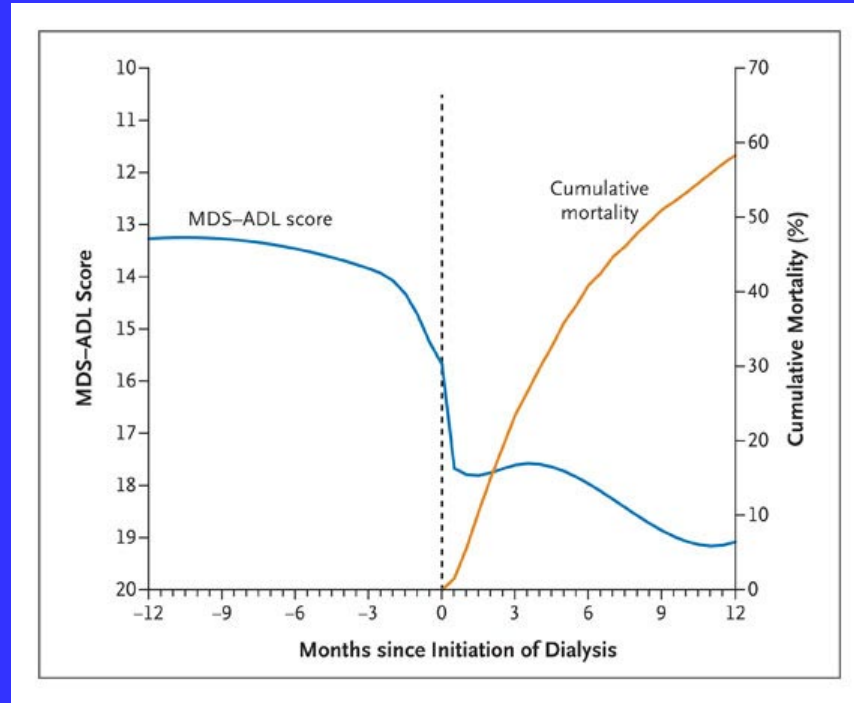
Depression 35%

Dementia 22%



Kurella Tamura et al. 361 (16): 1539, October 15, 2009

# Smoothed Trajectory of Functional Status before and after the Initiation of Dialysis and Cumulative Mortality Rate [Nursing home residents mean age 73]



Kurella Tamura et al. 361 (16): 1539, October 15, 2009



The NEW ENGLAND  
JOURNAL of MEDICINE

*Clinical Practice Guidelines on Shared  
Decision-Making in the Appropriate  
Initiation of and Withdrawal from Dialysis*

Renal Physicians Association of the USA 2010.

## Recommendation No. 6

It is reasonable to consider forgoing dialysis for ... ESRD patients who have a very poor prognosis or for whom dialysis cannot be provided safely.

1. Those whose medical condition precludes the technical process of dialysis because the patient :

(a) is unable to co-operate (eg. Advanced Dementia)

(b) unstable medically (eg. Significant hypotension)



2. Another life-limiting illness – although this may be negotiated

### 3. Over 75 years

with 2 or more of the following statistically significant criteria predictive of very poor prognosis :

- (a) Surprise question.
- (b) High Co-morbidity Score
- (c) Significantly impaired Functional status such as Karnofsky < 40,
- (d) Severe chronic malnutrition (s. Albumin < 25.)

# Conservative management of ESRD

This may be decided in consultation with a Nephrologist, or

The patient is not referred to a Nephrologist in the first place

What level of care occurs for this group ?

If this is being raised as an option :

What does a Conservative pathway mean ?

What is its content ?

Can we make predictions about their  
course ?

Challenge is

to ensure that this pathway of management is not seen as “second best” or inadequate

but is thorough, systematic and evidenced-based

## Renal Medicine

Blood Pressure

Calcium/Phosphate

Anaemia

Fluid balance

## Palliative approach

Symptom management

Psychosocial support

Care of the dying

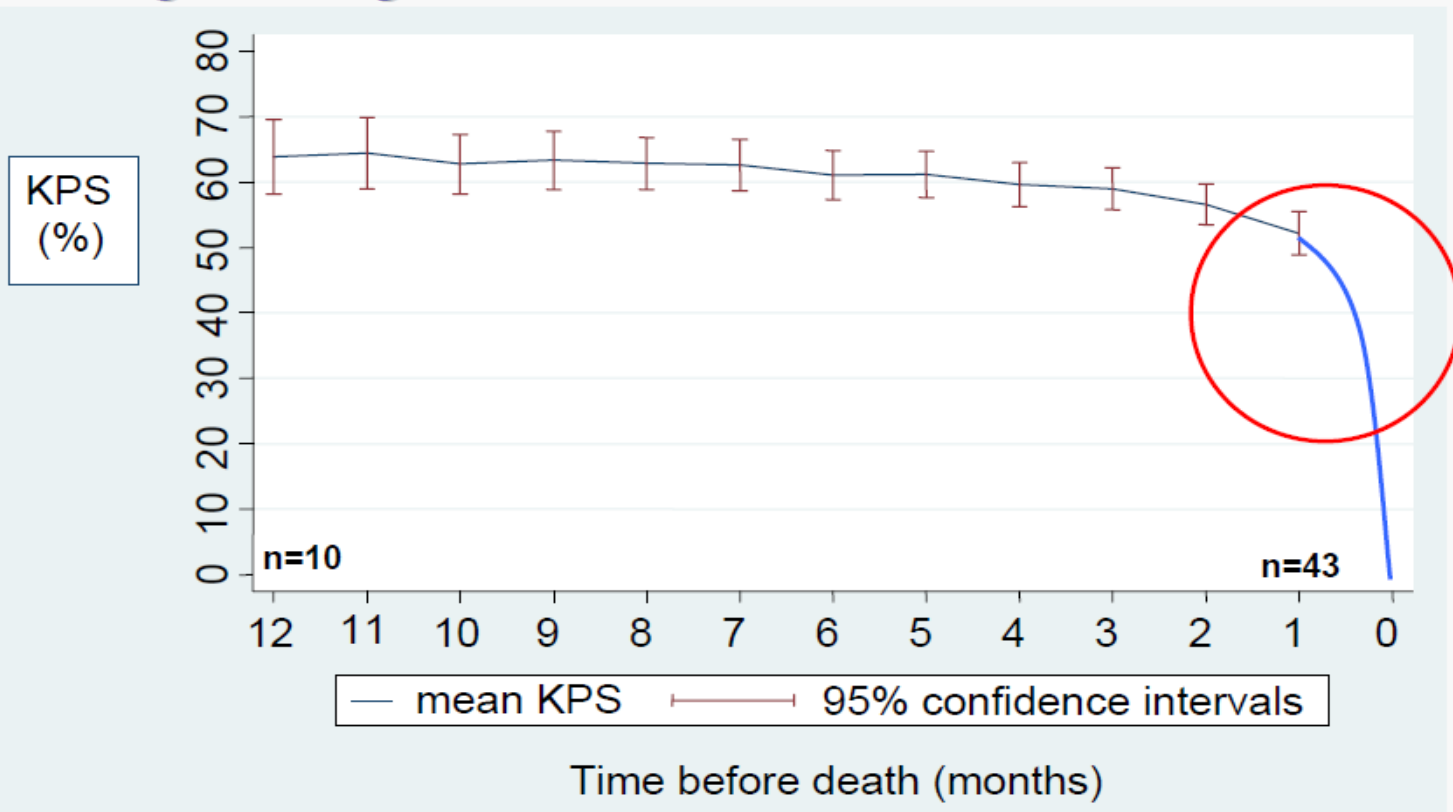


There is a modest, but growing body of literature of research on this cohort of patients.

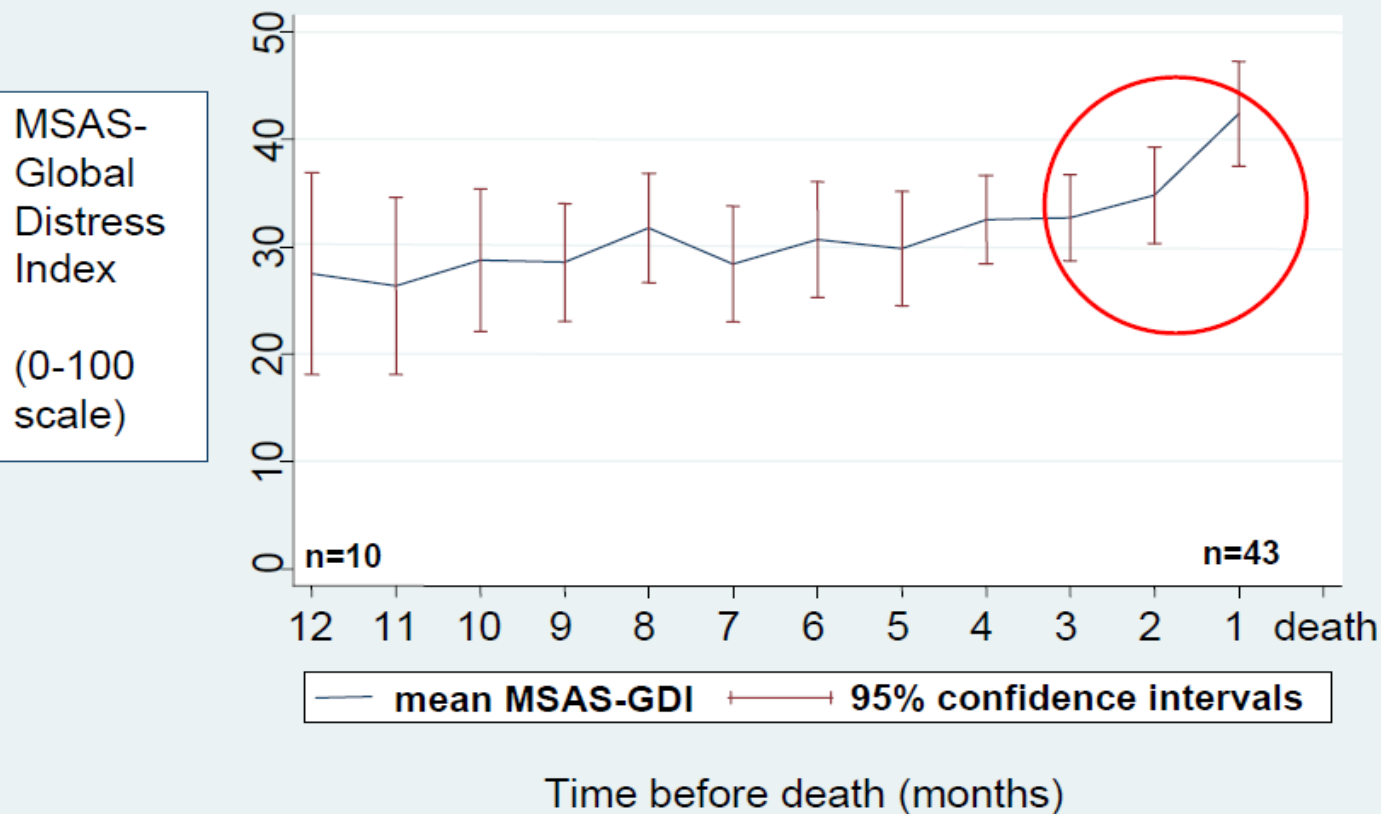
## Longitudinal study of conservative stage 5 CKD

- Included patients with Stage 5 Chronic Kidney Disease with definite decision for conservative (non dialysis) management, and with capacity for consent
- 73 participants (response rate 62%)
- 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
  - Symptoms (MSAS-SF)
  - Palliative needs (POS)
  - Functional status (KPS)

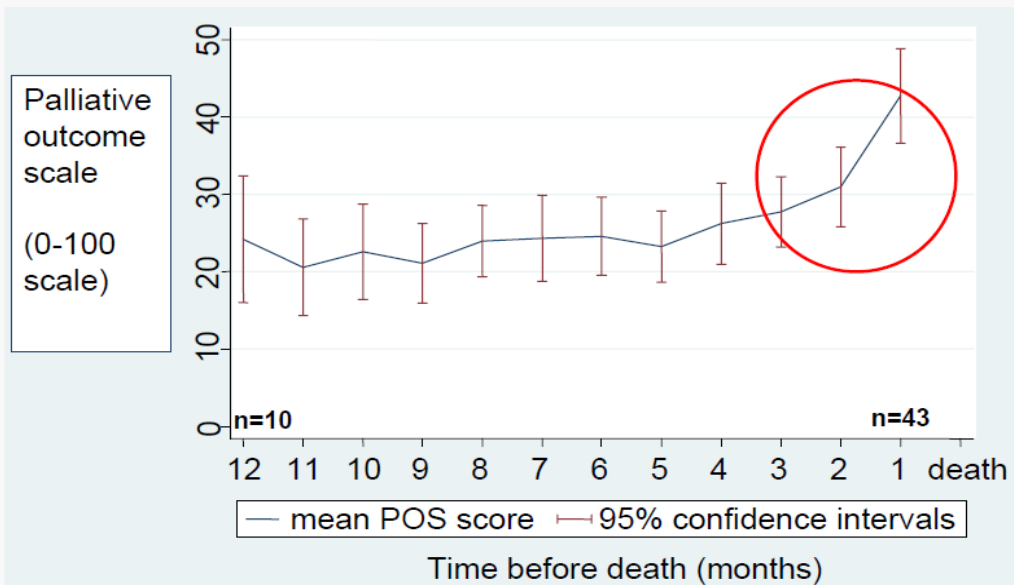
## Trajectory of functional status:



## Trajectory of symptom distress:



## Trajectory of palliative needs:



# Symptom management

# SYMPTOM PREVALENCE

	Dialysis	Conservative
FATIGUE/TIREDNESS	71%	75%
PRURITUS	55%	74%
CONSTIPATION	53%	
ANOREXIA	49%	47%
PAIN	47%	53%
SLEEP DISTURBANCE	44%	42%
ANXIETY	38 %	
DYSPNEA	35 %	61%
NAUSEA	33 %	
RESTLESS LEGS	30 %	48 %
DEPRESSION	27 %	

Symptom control is challenging



Symptoms interact and compound each other

Nocturnal :

U.Pruritus

RLS

Pain

Insomnia

Fatigue

Symptoms may derive from the co-morbidities

ESKD constrains the use of medication

Pharmacology in the context of CKD is complex

Multiple gaps in knowledge

Recommendations in published data occasionally conflict on the specific doses of medications to be used.

# Principles of symptom management

1. Think of the cause(s).
2. Be meticulous
3. Principle of non-abandonment



PAIN

# Impact on QOL

Davison (2002)

69 dialysis patients

62% stated that pain interfered with their ability to participate and enjoy recreational activities.

*Am J Kid Diseases* 2003; 42(6): 1239-1247

51 % stated that pain caused them “extreme suffering”

41 % stated that pain caused them to consider ceasing  
Dialysis

Positive correlation with depression

Davison S, Jhangri GS. J Pain Symptom Management 2005; 30(5): 465-473

# Causes of Pain

ESRD  
and its treatment

Co-morbidities

# ESRD and treatment

Disease related :

- Polycystic Kidney Disease
- Renal Bone Disease
- Amyloid
- Calciphylaxis

Dialysis-related pain :

- PD pts with recurrent abdominal pain
- AV Fistulae > 'Steal syndrome'
- Cramps

# Co-morbidities

- OA
- Diabetic neuropathy
- PVD / IHD



# Pain etiquette

- ENQUIRE REGULARLY
- RESPOND COMPASSIONATELY
- TREAT COMPETENTLY
- REFER WISELY

## Principles of pain management

1. Always enquire about pain.
2. Treat the underlying cause of the pain.
3. Treat the pain meticulously.
4. Treat the pain proportionately.
5. Constantly reassess.

# Step 1

Acetaminetophen

“It is considered the non-narcotic analgesic of choice for mild-moderate pain in CKD patients.”

Davison S, Ferro CJ. Management of Pain in CKD. *Progress in Palliative Care* 2009; 17: 186-195.

Acetaminophen at conventional doses is safe  
= 1 g qid

# Step 2

Tramadol

## Step 2

Tramadol “is the least problematic of the Step 2 Analgesics for ESRD patients”

Nevertheless use with caution – use a bd dose.

90 % of Tramadol and its metabolites are Renally excreted



Need for dose adjustment

If on Dialysis or  
on Conservative pathway eGFR 15-30

Commence 50mg bd

Maximum 100mg bd

If on a Conservative pathway  
eGFR < 15

Tramadol 50mg bd (maximum)

# Step 3

Morphine

Morphine

*Hepatic metabolism*

M-3-G

M-6-G

Kidneys

Morphine is not recommended in CKD

# Oxycodone

Short-acting

Endone

Oxynorm

Long-acting

Oxycontin

“Overall consensus is that Oxycodone is reasonably safe to use in CKD if monitored carefully.”

Davison SN et al *Seminars in Dialysis* 2014



Fentanyl

- Metabolised in Liver
- Inactive metabolites
- 5-10 % excreted unchanged renally
- Fentanyl is not dialysed

Fentanyl is safe to use at standard doses

Methadone

- Metabolised in liver
- Excreted mainly in the feces. Some renal excretion of Methadone and its metabolites
- Not dialysed
- Safe to use, but requires skill in dosing regimen – specialist use.

Davison SN, Konicki H, Brennan FP.

Pain in Chronic Kidney Disease : A Scoping Review.

*Seminars in Dialysis* 2014; 27(2): 188-204.

# RESTLESS LEGS SYNDROME

# Definition

1. An urge to move the limbs, usually associated with paresthesias/dysesthesias
2. Motor Restlessness
3. Symptoms exclusively while at rest, with relief (completely or partially) with movement.
4. Symptoms worse at night.

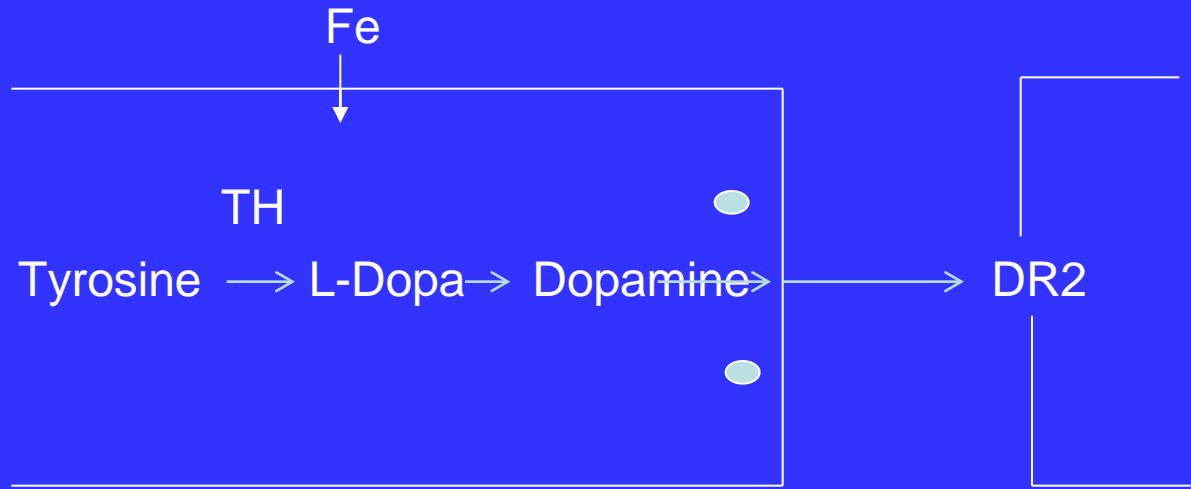
International RLS Study Group – Definition of RLS (1995)

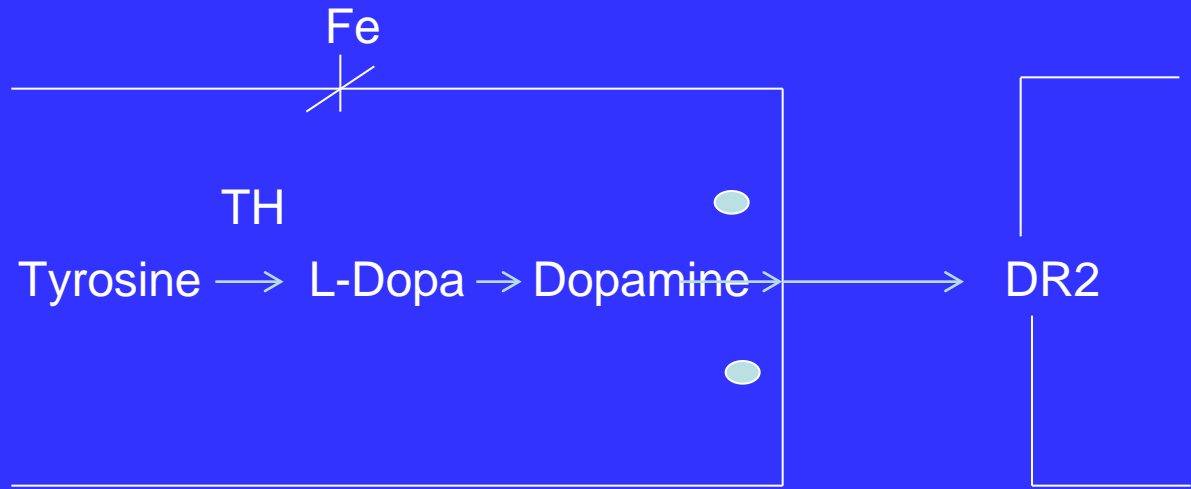


Incidence in the general population :  
2-15 %

Incidence in ESRD : 20-30 %

Mechanism is not completely understood





# Management

Clonazepam

0.5mg – 1mg nocte

Dopamine agonists

- Ergot-Dopamine Agonists (Pergolide, Cabergoline)
- Non-Ergot Dopamine Agonists (Pramipexole, Ropinirole, Rotigotine)

Gabapentin



Two Level 1 studies have shown efficacy for Gabapentin in the treatment of RLS in Dialysis patients

- Study A – Placebo controlled – Thorp et al (2001)
- Study B – Gabapentin compared to Levodopa – Micozkadioglu et al (2004)

## **On Dialysis**

Gabapentin 100mg after each Dialysis  
and titrating to effect

**On conservative management with  
eGFR < 15**

Gabapentin 100mg every second night  
and titrating to effect

**On conservative management with  
eGFR > 15**

Gabapentin 100mg nocte  
and titrating to effect

# URAEMIC PRURITUS

# Associations

- Poor sleep quality
- Depression
- QOL
- Mortality

Pisoni RL, Wikstrom B et al. Nephrol Dial Transplant 2006; 21: 3495-3505.

# The pathogenesis of pruritus



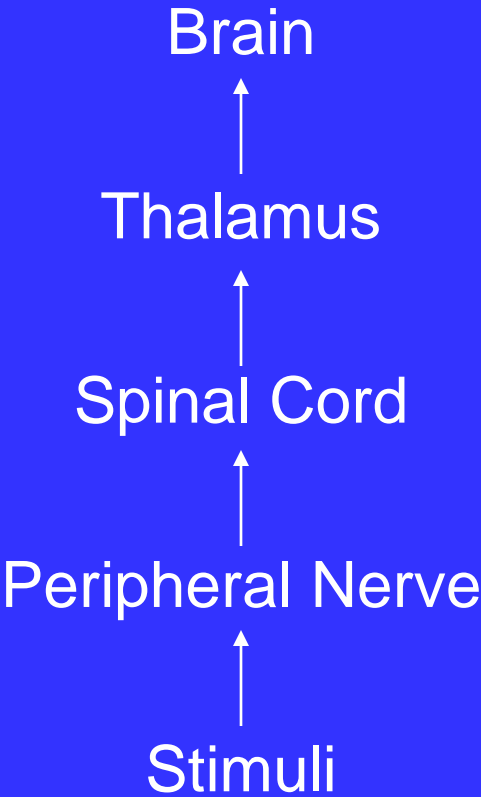
Epidermis



Dermis



Complex neural network within the dermis and nerve fibres enter the Epidermis as free nerve endings



C Fibres

5 - 10 % of the C fibres are itch sensitive

For many years the assumption was :

Histamine → C Fibres → Spinal Cord

Of the C Fibres that are itch-sensitive :

20 % are Histamine-sensitive

80 % are Histamine-insensitive

# Myth 1

That all itch is histamine mediated

## Myth 2

That the best first line medication for pruritus of whatever cause are Anti-Histamines



# Pathogenesis of Uraemic Pruritus

Multiple theories, conflicting findings

“Despite this vast array of possible explanations, none consistently have been demonstrated to be the underlying cause of pruritus associated with CKD. Large epidemiological studies ultimately may facilitate our understanding of the elusive pathophysiological process of this distressing symptom.”

Patel TS et al. *Am J Kidney* 2007; 50(1): 11-20.

Large number of therapies described

What therapies have the strongest foundation in evidence  
– based practice ?

- Oral medications
- Topical preparations
- UV Therapy

**Gabapentin**

There are 3 (three) Level 1 studies showing that Gabapentin has significant efficacy in treating uraemic pruritis

Gunal et al (2004)

Naini et al (2007)

Razeghi et al (2009)



# Evening Primrose Oil

Gamma Linolenic Acid (GLA)

Essential Fatty Acids (EFA)  
in the epidermis

## n- 6 EFA

Linolenic Acid (LA)



Gamma-Linolenic Acid (GLA)



DGLA



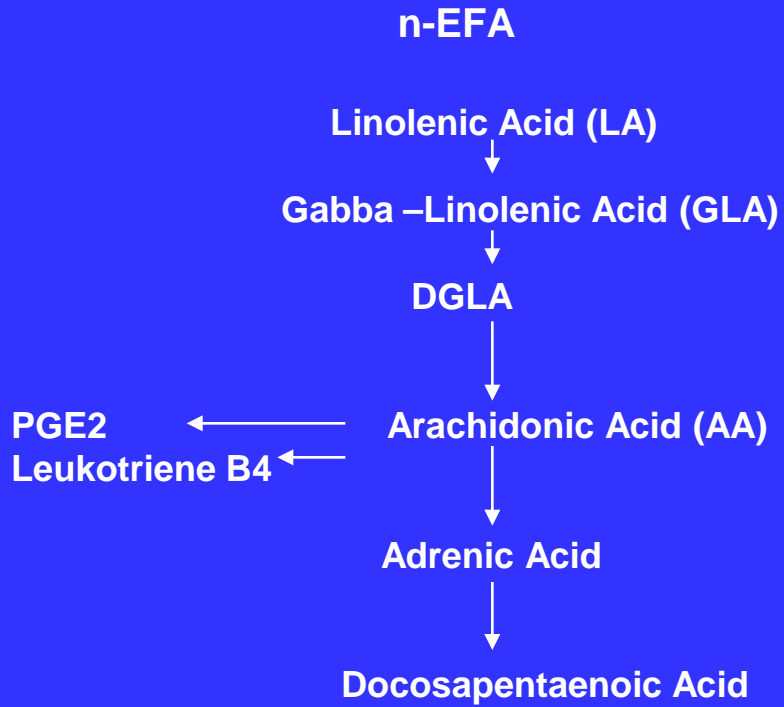
Arachidonic Acid



Adrenic Acid



Docosapentaenoic Acid



# n- 6 EFA

Linolenic Acid (LA)



Gamma -Linolenic Acid (GLA)



DGLA

PGE1



15 -OH DGLA



Arachidonic Acid (AA)



Adrenic Acid



Docosapentaenoic Acid



So supplementing the Gamma-Linolenic Acid (GLA) has an anti-inflammatory/ anti-itch effect

100mg bd

= Evening Primrose Oil  
contains GLA  
= 2 capsules bd



Thalidomide 100mg nocte

Silva SR. *Nephron* 1994;  
67(3): 270-273

# Other oral medications

- Anti-Histamines – evidence does not support use.
- Ondansetron – conflicting results. Not recommended.
- Cimetidine – not recommended
- Naltrexone – conflicting results. Not recommended.

Murtagh FEM, Weisbord D . Symptom management in Renal Failure. In : Chambers EJ et al (eds). *Supportive Care for the Renal Patient*. 2<sup>nd</sup> ed. 2010. OUP. p. 120

Topical preparations

Capsaicin cream (0.025 %)

Side effect – transient “burning” feeling on the skin

# UV-B Therapy

Hassan H et al.

Efficacy and Safety of Gabapentin for  
Uremic Pruritus and Restless Legs  
Syndrome in Conservatively Managed  
Patients With Chronic Kidney Disease

*J Pain & Symptom management* 2014 (In  
Press)

Of all CKD patients on a conservative pathway  
who presented to the RSC clinic with uraemic pruritus  
47 % reported its severity as severe to overwhelming.

At Clinic 4 (median 12.6 weeks) -

85 % reported nil to slight pruritus and no patients reported severe or overwhelming severity.



A 53 year old woman

- Type 2 Diabetes Mellitus
- Hypertension
- OA – mild
- ESKD – Diabetic Nephropathy
- HD 3/week for 5 years

Referred to clinic because of extreme :

1. Uraemic Pruritus
2. Restless Legs Syndrome
3. Diabetic PN
3. Very poor sleep

Gabapentin

Gabapentin commenced for all conditions at 200mg at the completion of each dialysis.

- Complete cessation of all symptoms and a markedly improved sleep
- Sleeping “*the best I have for a long time.*”

# Care of the dying patient with ESKD

ESKD patients may die :

- Having been on dialysis
- Never having been on dialysis

Patients with ESKD on dialysis may die in many different ways



The family's view of the manner of dying and the care given will have a major effect on their bereavement and will echo down the years in the way they view death.

A major sentinel event → Sudden death

The “negotiated withdrawal”

- George has been on dialysis for 6 months
- He is increasingly fatigued and more frail. No clear reversible cause.
- Further exacerbations of Chronic Airways Limitation.
- NSTEMI
- He presents with a gangrenous toe - post amputation, worsening gangrene... discussion about further surgery.

# Nephrologist 1

“Its time to talk to him and his family about the future. We need to be honest. It is right to say to him that he could withdraw from dialysis at any time, that would be OK. We would then speak about what to expect from that point onwards including our care for he and his family.”

## Nephrologist 2

“If he brings it up of course I will talk to him...but only if he raises it. It should come from him.”

It is important that any discussion about withdrawal is open and honest  
at the patient's own pace  
and includes the family.

- What should I expect ?
- Will I suffer ?
- Will I drown in fluids ?
- How long will I live ?



Patients survive a variable time.

- If completely anuric – 7-10 days
- If still passing urine – weeks-months



**HOPE**

The preservation and maintenance of  
hope

Resetting the focus of care

I agree that there is no hope for cure,  
but there is hope that you will be  
comfortable and supported throughout.



**Not be abandoned.**

**Always be listened to.**

**All symptoms treated to  
the best of our ability.**

**Will not needlessly  
suffer.**

**Treated with respect  
and dignity at all  
times.**

“A crisis withdrawal”

# Scenario 1

The major sentinel event occurs ...

- Family prepared for imminent death
- Dialysis ceased
- Consensus that there will not be an escalation to ICU etc.

# Scenario 2

The major sentinel event occurs...



- No discussion about withdrawal
- Waiting approach
- Patient dies on dialysis, the day of dialysis

This scenario is considerably assisted if there the patient has had prior conversations with their Nephrologist including

an Advance Care Plan

**Creating and nurturing  
a Renal Supportive Care service**

St George Hospital, Sydney, Australia

Collaboration between the departments of Renal  
Medicine and Palliative Medicine.

# Formation of a Renal Supportive Care Clinic

March 2009

- Held every week
- Held in the Renal Unit
- Palliative Care Consultant, Advanced Trainee in Renal Medicine, Renal Clinical Nurse Specialist and Renal Social Worker

All patients with ESKD according to needs

Main categories of patients who are referred to the clinic :

- Patients who are on a conservative pathway
- Patients who need assistance in decision making around choosing dialysis or not
- Patients who are on dialysis and have cancer or other terminal conditions.



- Patients on dialysis who are experiencing symptoms which are difficult to manage
- Patients on dialysis who need assistance in decision making regarding withdrawing or continuing with dialysis

- Focus on symptom management
- Psychosocial support
- Preliminary discussions on ACP
- Access to Renal Social Worker and Renal Dietician

Ref No: Date: **Questionnaire POS-S (renal) – staff version**

Below is a list of symptoms which the patient may or may not have experienced. Please record how these symptoms have affected the patient in the table below. Put a tick in the box to show how you think they have affected how they have been feeling **over the last week**.

	Not at all, no effect	Slightly – but not bothered to be rid of it	Moderately – limits some activity or concentration	Severely – activities or concentration markedly affected	Overwhelmingly – unable to think of anything else
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea (feeling like you are going to be sick)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting (being sick)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless legs or difficulty keeping legs still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Any other symptoms?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which symptom has affected the patient the most? .....

Which symptom, if any, has improved the most? .....

Teaching programme for Junior  
Medical Staff, including Nephrology  
Trainees on all aspects of Renal-  
Supportive Care

Preparation of documents :

(a) End of Life Pathway for Renal Patients

(b) Commonly used Palliative medications  
in the context of CKD

(c) A Renal-Palliative Care Reader

# Annual Renal Memorial Service

# Annual Renal Palliative Care Symposium

2010 - 2014

# Renal Supportive Care Curriculum

- Master classes for trainees



**What are the best books  
and materials in this area ?**

Chambers EJ, Germain M, Brown E (eds)

*Supportive Care for the Renal Patient*

2<sup>nd</sup> edition, 2010

Oxford University Press

Brown E, Murtagh F, Murphy E.(eds) *Kidney Disease – From Advanced Disease to Bereavement*. 2<sup>nd</sup> ed, 2012. Oxford Handbooks.

# **Clinical Practice Guideline on Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis**

Renal Physicians Association of the USA and the American Society of Nephrology. 2010.

# Australasian Renal Supportive Care Position Statement

Endorsed by Kidney Health Australia

Endorsed by the Australian and New Zealand Society of  
Nephrology

*Nephrology* 2013;18(6)

*End-of-life Framework : Recommendations for a Provincial  
EOL Care Strategy 2009*

Work of the BC Provincial Renal Agency

# Conclusion

A mutual acknowledgement of need-

The role of Palliative Care/supportive care in ESRD

The last decade has seen considerable levels of advocacy, attitudinal shift, research, publications and collaboration



This approach may come at multiple points in the trajectory of the disease

The core competencies in a “Palliative approach” to patients with ESKD

can and should be acquired by all doctors working with these patients.

Applies to patients who are being managed either with dialysis or conservatively

The family will remember forever your involvement, your  
demeanour and your compassion

Your patients remain your patients until their death