

## Interdisciplinary Approach to the Palliative Treatment of Patients with Kidney Disease, either Acute or Chronic

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### Abstract

The interdisciplinary approach used in palliative care, which was established to satisfy the needs of patients with a life-threatening illness and their families, has drawn more attention in recent years. Most clinical realities still reserve palliative care for patients who are nearing the end of their lives, leading to confusion between hospice care and palliative care even though the modern concept of palliative simultaneous care postulates the adoption of these high-quality treatments early in the course of the life-threatening disease (and possibly just after the diagnosis). Patients with acute or chronic kidney disease (CKD) typically have a poor quality of life and a lower chance of survival; as a result, palliative care may be beneficial. In order to discuss the diagnosis, prognosis, practical treatment objectives, and treatment decisions, palliative care involves close collaboration between several healthcare professionals, patients, and their families. To fully address the demands of patients with kidney disease, a variety of strategies, including peritoneal palliative dialysis, extracorporeal, and conservative therapy, can be used (e.g., physical, social, psychological, or spiritual needs). Pharmacologic medication or peritoneal dialysis may be more suitable than extracorporeal therapy, especially for fragile patients. Treatment with extracorporeal dialysis may be excessive in these individuals and be accompanied by a heavy load of symptoms connected to this invasive therapy. Individualized goal-setting and a more expansive definition of sufficiency should be taken into consideration as the cornerstones of extracorporeal palliative dialysis for patients receiving extracorporeal dialysis. Surprisingly, there is little research on the palliative and end-of-life care provided to individuals with acute kidney injury (AKI). The primary factors affecting medical decisions on palliative care for patients with renal illness are discussed in this study, along with the many methods that can meet the needs of patients with CKD and AKI.

**Keywords:** Palliative care; Chronic kidney disease; End-stage kidney disease; Acute kidney injury

### Introduction

Multidisciplinary approaches used in palliative care are intended to assist doctors in caring for patients with life-threatening diseases [1, 2]. This cutting-edge viewpoint was created to acknowledge and address the requirements of patients with a life-threatening illness and their families. It is primarily based on a multidimensional analysis, which entails identifying and managing patients physical, psychological, and social needs as well as their spiritual and social needs, evaluating patients clinical conditions and prognoses to set appropriate and realistic treatment goals, creating individualised treatment plans in accordance with patients preferences, paying attention to families needs, and supporting healthcare professionals [2].

Patients who have had curative therapies deemed to have failed are now seen to be the most suited candidates for palliative care [1,3]. Because of this, the majority of healthcare professionals refer to palliative care as being synonymous with end-of-life care and beginning when life-prolonging therapies are stopped [3]. However, reserving palliative care until the very end of life may leave patients unable to manage their physical and emotional symptoms for the duration of their illness [3]. Nowadays, it is advised to provide both palliative care and life-sustaining therapies simultaneously to patients who are critically and non-critically sick, starting with those who have been diagnosed with a serious illness (such as cancer or chronic organ malfunction). Palliative care is neither an exclusive alternative to intense curative therapies nor a follow-up to vain attempts to extend patients lives under this paradigm of simultaneous care [1,2]. All patients with a life-threatening disease might essentially receive simultaneous care, regardless of their age, comorbidities, or fragility. Instead, palliative care is suitable at any age, at any stage of a serious disease, and may be delivered in combination with curative therapy,

according to the definition created by the Center to Advance Palliative Care and the American Cancer Society. On the other hand, patients who get restorative therapy but forgo curative therapies and have an estimated lifespan of fewer than six months should receive end-of-life care [1,3]. Despite recent breakthroughs in treatment approaches, patients with acute kidney injury (AKI), chronic kidney disease (CKD), and notably end-stage kidney disease (ESKD) have shorter lives than people without kidney disease. The survival rates of these individuals can be improved using extracorporeal kidney replacement treatments (KRTs). The dying process for these individuals may be unnecessarily prolonged and made worse by these operations in some subgroups of acute, severely sick end-of-life patients [1].

The need for dialysis is rising gradually around the world, especially among older patients. Extracorporeal dialysis was used by 55% of patients with ESKD who were 65 years or older in 2005, as shown by the European Renal Association-European Dialysis and Transplant Association (ERA-EDTA) [4]. From 1980 to 2005, this number more than doubled. The majority of these patients receive KRT three times a week at an outpatient dialysis facility, necessitating frequent travel, which can be difficult for older and weak patients in particular [5,6].

These methods have been highly successful in extending life

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**Received:** 31-Aug-2022, Manuscript No. jpcm-22-75824; **Editor assigned:** 02-Sep-2022, PreQC No. jpcm-22-75824(PQ); **Reviewed:** 16-Sep-2022, QC No. jpcm-22-75824; **Revised:** 21-Sep-2022, Manuscript No. jpcm-22-75824(R); **Published:** 28-Sep-2022, DOI: 10.4172/2165-7386.1000478

**Citation:** Shah P (2022) Interdisciplinary Approach to the Palliative Treatment of Patients with Kidney Disease, either Acute or Chronic. J Palliat Care Med 12: 478.

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expectancy during ESKD thanks to technological advancements that characterise the maintenance of hemodialysis. Nevertheless, the high death rate for ESKD patients receiving maintenance hemodialysis, which is currently estimated at around 23% annually [1], is a result of the high incidence of other non-renal chronic disorders (mostly metabolic and/or cardiovascular comorbidities). A deterioration of physical, psychological, and social situations is also frequently seen within the first year after starting hemodialysis [1,6], in addition to a decrease of overall functional status. The maintenance hemodialysis-induced symptom load is equivalent to the symptom burden caused by chemotherapy for advanced cancer [1]. For these patients, palliative care should be taken into account. The use of proactive and early palliative care integration in the treatment of CKD patients has been shown to enhance patient outcomes. It's interesting to note that, especially in these extremely complicated diseases, only a multi-professional team can completely satisfy the patients demands. As a team, all doctors treating patients with severe CKD are urged to aggressively foster communication with patients and their families. These medical specialists, in accordance with their areas of specialisation and experience, are responsible for choosing the occasions, situations, and circumstances in which to begin the debate on renal maintenance replacement or palliative care. The nephrologist in particular is familiar with the course of renal illness, and the doctor deals with primary requirements and palliative care while being aware of the socioeconomic, familial, and psychological circumstances that affect patients and their families.

There are other ways to meet the patients demands and enhance quality of life besides the dynamic KRT adjustment and ongoing discussion of its aims. A significant number of patients regret beginning extracorporeal therapies and choose conservative therapy of ESKD as a result after speaking with and agreeing with caregivers. Planning the right care management for patients with ESKD requires providing patients, their families, and caregivers with education, information, and support. Peritoneal dialysis (PD) and conservative therapy (see below) are two more treatment choices that should be thoroughly addressed and shared with patients, families, and carers. Palliative medicine should be taken into consideration for patients receiving KRT and those who are treated with conservative therapy in order to enhance their quality of life.

Hemodialysis is a common kind of therapy for ESKD kidney replacement. Kt/V, or the urea clearance normalised to total body urea, is typically used to quantify the appropriateness of the solute clearances in extracorporeal therapies. Given the connection between Kt/V and mortality in the past, this measurement has been employed to help tailor recommended therapies. However, the concerted attempt to personalize therapy has also encouraged a critical review of particular aims, which should try to improve the patients complete clinical picture rather than just remove the solute. Although acceptable, this idea is still far from being the norm in the majority of dialysis facilities [1]. For patients who are neither candidates for or resistant to KRT, conservative treatment is a possibility. To stop the major effects of ESKD, such as hydro-electrolyte imbalance, acid-base disorders, azotemia, and anaemia, it involves pharmaceutical and behavioural methods. The majority of geriatric patients are candidates for conservative care, especially if they are fragile and/or suffer from dementia. There is also peritoneal dialysis (PD) as a method for treating renal illness. Compared to hemodialysis and cautious management, it may provide benefits. Hemodialysis can be hampered by hemodynamic instability and severe hypotension, which deteriorates the clinical state of weak patients. Since PD offers gradual, continuous solute clearance and net ultrafiltration, preserves better renal functions, and permits less limited, more manageable diets,

it is seen as a less intrusive therapy. Patients who are frail typically cope with PD better and can preserve their quality of life. Similar to hemodialysis, PD can counteract metabolic acidosis and fluid overload, which can exacerbate symptoms while receiving conservative treatment. However, domiciliary treatment and infrequently planned outpatient visits can also manage PD, making them a viable alternative [1].

### Palliative Care For AKI Patients

Between 36% and 67% of critically sick patients in ICUs have had AKI instances overall. The mortality rate is remains striking despite possible numerous pathophysiological processes and etiologies [1,7]. In fact, severe AKI is associated with a poor prognosis, particularly considering the seriousness of the illness, the necessity for extracorporeal renal support, and the requirement for multiorgan dysfunction, and the ideas of palliative and end-of-life care are yet underdeveloped in these situations. In spite of the increased interest in palliative care for critically ill patients, very few publications on the withdrawal or cessation of invasive therapies in instances of AKI have been published in the scientific literature. As a result, even while palliative and hospice care management is thoroughly taken into account in people with CKD, there is still a dearth of general guidelines for people who are ill suddenly and have AKI. Recent years have seen a rise in the number of critically ill patients who satisfy the requirements for KRT commencement; nevertheless, there are still significant questions about the efficacy of this approach [1,8]. Nevertheless, despite the development of focused diagnostic and therapeutic approaches, mortality in critical care remains quite high. Even if they can only unnecessarily delay the dying process, advanced life-support technologies such acute KRT are a possibility. In the literature for various life support systems such mechanical ventilation, extracorporeal membrane oxygenation, or extracorporeal CO<sub>2</sub> removal, similar ethical scandals may be discovered. In the literature, a number of instruments have been suggested with predictive intents and the goal of assisting doctors in directing extracorporeal therapy. Other methods have been put out to identify individuals who are nearing the end of their lives and for whom stopping or reducing their therapies would be suitable [9]. Unquestionably, a key limiting element is clinical feasibility. Although some patients clinical circumstances, such as severe hypotension, may have a deleterious effect on technical feasibility, the majority of patients may now get KRT thanks to approaches such continuous renal replacement therapy. Survival prognosis is an important consideration in deciding whether to continue, stop, or withdraw KRT, and this consideration cannot be ignored by appropriate medical judgement backed by informed consent. Despite the availability of various outcome prediction models and organ dysfunction grading systems, none of them adequately indicate if KRT is appropriate for a certain patient. Worldwide mortality rates for AKI and KRT patients range from 47% to 75%. In a decision-making process, a prediction of renal recovery following AKI must also be considered along with other parameters for the aim of defining long-term renal and non-renal outcomes. The quality of life of patients and their families may significantly decline during ESKD and if maintenance hemodialysis is necessary after AKI. However, there hasn't been much research done in the literature on long-term results and quality of life in critically ill patients requiring KRT. For instance, the SUPPORT research found that critically ill patients with AKI who survived showed an average of one reliance in daily living tasks, however other studies have reported different findings.

## Conclusion

Palliative care, which is sometimes mistaken with hospice care, is primarily targeted at all cases of patients with serious illnesses who are in the final phase of the condition. Early use of palliative care can improve quality of life and help families in all of the aforementioned instances. Palliative care, which is a well-defined concept specifically for CKD rather than AKI, might assist renal patients because they often have a shorter life expectancy. In fact, many treatment approaches, such as palliative dialysis, conservative care, and PD, can be followed to enhance the quality of life in CKD patients. Each of these treatments calls for close communication between medical staff, patients, and families. Each of these treatments calls for close communication between medical staff, patients, and families. All involved parties must agree on the prognosis, reasonable treatment objectives, and therapy choices. The literature contains few and insufficient information about the impact of palliative and hospice treatment for AKI patients. In order to implement knowledge and understanding of this understudied issue, methodological, ethical, and therapeutic efforts are required.

## Acknowledgement

Not applicable.

## Conflicts of Interest

Author declares no conflict of interest.

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