Tõendusmaterjali kokkuvõte - EvSu

Kliiniline küsimus nr 20

Kas kõikidel kroonilise neeruhaigusega patsientidel tuleb ravitulemuste parandamiseks ravimeetodi valikul (konservatiivne ravi, neeruasendusravi) hinnata patsiendi seisundit ja soovi (informeeritud otsus) vs mitte?
Tulemusnäitajad: kroonilise neeruhaiguse ravi tulemuslikkus, ravikulu, ravisoostumus, kroonilise neeruhaiguse progresseerumine, südame-veresoonkonna tüsistused, hospitaliseerimine, neeruasendusravi, patsiendi elukvaliteet, elulemus, üldsuremuse vähenemine

Kliinilise küsimuse vastamiseks otsiti materjali eelnevalt sekretariaadi poolt Agree II meetodil hinnatud ravijuhenditest

- Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. **KDIGO 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease** (Kidney inter., Suppl. 2013; 3: 1-150; http://www.kdigo.org/clinical_practice_guidelines/pdf/CKD/KDIGO_2012_CKD_GL.pdf) **(KDIGO)**
- National Clinical Guideline Centre; National Institute for Health and Care Excellence. **Chronic kidney disease (artial update). Early identification and management of chronic kidney disease in adults in primary and secondary care**. Clinical Guideline 182. 2014 (http://www.nice.org.uk/guidance/cg182/evidence/cg182-chronic-kidney-disease-update-full-guideline3) **(NICE)**
- Academy of Medicine of Malaysia: **Management of Chronic Kidney Disease**, 2011 (http://www.acadmed.org.my/index.cfm?&menuid=67) **(Mal)**
- KHA-CARI Guideline: **Early chronic kidney disease: Detection, prevention and management**.2013 (http://www.cari.org.au/CKD/CKD%20early/ckd_early_ckd.html) **(CARI)**
- Scottish Intercollegiate Guidelines Network**: Diagnosis and management of chronic kidney disease**. A national clinical guideline 103. 2008. (http://www.sign.ac.uk/pdf/sign103.pdf) **(SIGN)**

Täiendavalt otsisime viimasel viiel aastal (aastast 2011.a) avaldatud teemakohaseid artikleid.
PubMed, SumSearch2: otsindusõnad - Renal replacement therapy and prognosis, Renal replacement therapy and patient decision, CKD treatment and patient decision, Dialysis and prognosis, End-of-life care and CKD, Conservative kidney management, Conservative kidney management and prognosis, Conservative kidney management and quality of life, Conservative kidney care and prognosis, Conservative kidney care and quality of live, CKD and quality of life, Supportive care and CKD, Supportive care and prognosis and CKD, Supportive care and life expectancy and CKD, Palliative care and CKD, Palliative care and prognosis and CKD, Predialysis education

Süstemaatilised ülevaated

Leitud 5 artiklit.

1. Süstemaatiline ülevaade (**Nina R. O'Connor and Pallavi Kumar, 2012)**, põhineb 13 uuringu andmetel. Ülevaate eesmärgiks on: teha kokkuvõte uuringutest, mis hindasid prognoosi, sümptomite esinemist ja elukvaliteeti sümptomaatilist ravi saavatel KNHga patsientidel.
2. 2016 aastal publitseeritud süstemaatiline ülevaade ja meta-analüüs **(Celine Foote et al.)** elulemuse kohta erinevates ravirühmades lõppstaadiumi neeruhaigetel. Analüüs põhineb 89

uuringu andmetel. 6 uuringus oli võrreldud 1 aasta eulemust dialüüsravil ja toetaval ravil patsientide vahel.
3. 2015 aastal publitseeritud artikkel (**Mario Pacilio et al.)**, artiklis on süstemaatiline ülevaade NAR vs konseravtiivse ravi kohta ning lisaks ka üks haigusjuht. Ülevaade hõlmab 11 uuringut, 2 neist on RCT. Ülevaate eesmärgiks oli võrrelda elulemust dialüüsravil ja konservatiivsel ravil patsientide rühmades.
4. Euroopas läbiviidud uuringutel põhinev **Mi-Kyung Song** artikkel **(2016)** on ülevaade sümptomite esinemisest ja elukvaliteedist konservatiivse ravi korral. Lisaks artiklis kirjeldatud patsiendipoolsed faktorid, mis avaldavad mõju ravimeetodi valikul (dialüüs vs konservatiivne ravi).
5. **Sarah Tonkin-Crine et al. (2014)** kvalitatiivne uuring, mille eesmärgiks oli hinnata patsiendipoolseid põhjusi neeruasendusravi valikul (eeskätt konservatiivse ravi valik).

Viited

Kokkuvõtte (abstract või kokkuvõtlikum info)	**Viide kirjandusallikale**
1. Nina R. O'Connor and Pallavi Kumar. Conservative Management of End-Stage Renal Disease without Dialysis: A Systematic Review. JOURNAL OF PALLIATIVE MEDICINE Volume 15, Number 2, 2012. DOI: 10.1089/jpm.2011.0207 **Abstract:** **Purpose:** To summarize evidence on conservative, nondialytic management of end-stage renal disease regarding 1) prognosis and 2) symptom burden and quality of life (QOL). **Methods:** Medline, Cinahl, and Cochrane were searched for records indexed prior to March 1, 2011. Bibliographies of articles and abstracts from recent meetings were reviewed. Authors and nephrologists were contacted to identify additional studies. Articles were reviewed by two authors and selected if they described stage 5 chronic kidney disease (CKD) patients managed without dialysis, including one or more of the following outcomes: prognosis, symptoms, or QOL. Levels of evidence ratings were assigned using the SORT (Strength of Recommendation Taxonomy) system. Data was abstracted independently by two authors for descriptive analysis. **Results:** Thirteen studies were included. In studies of prognosis, conservative management resulted in median survival of at least six months (range 6.3 to 23.4 months). Findings are mixed as to whether dialysis prolongs survival in the elderly versus conservative, nondialytic management. Any survival benefit from dialysis decreases with comorbidities, especially ischemic heart disease. Patients managed conservatively report a high symptom burden,	**http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3318255/pdf/jpm.2011.0207.pdf**

underscoring the need for concurrent palliative care. Additional head-to-head studies are needed to compare the symptoms of age-matched dialysis patients, but preliminary studies suggest that QOL is similar. **Conclusions:** Conservative management is an important alternative to discuss when counseling patients and families about dialysis. Unlike withdrawal of dialysis in which imminent death is expected, patients who decline dialysis initiation can live for months to years with appropriate supportive care.

TABLE 1. STUDIES INCLUDED IN SYSTEMATIC REVIEW

Reference	*Study design*	*Study follow-up*	*Level of evidence*[a]
Carson et al., 2009[21]	Prospective cohort study of patients with GFR<30 and age ≥70 receiving either CM or dialysis	95.0%	1
Chanda et al., 2010[17]	Retrospective cohort study of patients with GFR<15 receiving either CM or dialysis	n/a	2
Ellam et al., 2009[19]	Retrospective cohort study of patients with GFR<15 receiving CM	n/a	2
Joly et al., 2003[20]	Prospective cohort study of patients with CrCl<10 and age ≥80 receiving either CM or dialysis	100%	1
Murtagh et al., 2007[18]	Retrospective cohort study of patients with GFR<15 and age >75 receiving either CM or dialysis	n/a	2
Smith et al., 2003[15]	Prospective cohort study of patients with GFR<15 recommended for CM by multidisciplinary team	100%	1
Wong et al., 2007[16]	Prospective cohort study of patients with GFR<30 receiving CM	100%	1
DeBiase et al., 2008[29]	Observational study of patients with age >75 and GFR<15 recommended for CM	n/a	2
Murphy et al., 2009[25]	Cross-sectional survey of patients with GFR<30 receiving CM	n/a	2
Murtagh et al., 2007[22]	Cross-sectional survey of patients with GFR<15 receiving CM	n/a	2
Murtagh et al., 2010[23]	Longitudinal survey of patients with GFR<15 receiving CM, data presented from the month prior to death	n/a	2
Saini et al., 2006[24]	Cross-sectional survey of patients with GFR<15 receiving CM; survey also administered to comparison group of patients with terminal malignancy	n/a	2
Yong et al., 2009[28]	Cross-sectional survey of patients with GFR<15 receiving either CM or dialysis	n/a	2

GFR, glomerular filtration rate; CM, conservative management; CrCl, creatinine clearance; n/a, not applicable.
[a]Based on Strength of Recommendation Taxonomy (SORT) criteria: level of evidence 1=good-quality, patient-oriented evidence; level of evidence 2=limited-quality, patient-oriented evidence; level of evidence 3=other evidence.

Süstemaatiline ülevaade publitseeritud 2012, selle eesmärgid: teha kokkuvõte uuringutest, mis hindasid prognoosi, sümptomite esinemist ja elukvaliteeti sümptomaatilist ravi saavatel KNHga patsientidel. 13 uuringut, 7 prospektiivset ja retrospektiivset kohortuuringut, neljal uuringul tõenduspõhisus on "hea", ülejäänud uuringutel "piiratud". Tulemused: nendes uuringutes, mis hindasid prognoosi haigete keskmine elulemus konservatiivsel ravil oli 6 kuud (6-23 kuud), dialüüsravil patsientide elulemust mõjutas oluliselt kaasuvate haiguste esinemine, eriti südame isheemiatõbi. Sümptomite esinemine konservatiivsel ravil olevate haigete seas oli kõrge. Elukvaliteet oli hinnatud 3 võrdlusuuringus (konservatiivne ravi vs dialüüs; KNHga pt konservatiivsel ravi vs pahaloomulise kasvajaga haige). Elukvaliteedi osas

olulist erinevust ei olnud.	
2. Celine Foote et al. Survival outcomes of supportive care *versus* dialysis therapies for elderly patients with end-stage kidney disease: A systematic review and meta-analysis. *Nephrology* **21** (2016) 241–253 **Abstract:** **Aim:** Elderly people comprise a large and growing proportion of the global dialysis population. Regional differences in rates of dialysis in the elderly suggest multiple factors influence treatment decision-making including beliefs about the relative benefits and harms of dialysis and supportive (non-dialysis) care. We therefore systematically reviewed the literature reporting survival of elderly patients treated with either treatment pathway. **Methods:** Systematic review and meta-analysis of cohort studies or randomized controlled trials identified in MEDLINE, EMBASE and the Cochrane Central Register of Controlled Trials published before July 2014. Survival by treatment modality was calculated. Subgroup analyses by study design, study size, patient age and cohort era were conducted. **Results:** Eighty-nine studies published between 1976 and 2014 reported on 294 921 elderly end-stage kidney disease (ESKD) patients. There was a paucity of data for supportive care (724 patients or 0.2% of the total patients) and supportive care studies were susceptible to lead-time bias. One-year survival for elderly patients treated with undifferentiated dialysis was 73.0% (95% confidence interval (CI) 66.3–79.7%), 78.4% (95% CI 75.2– 81.6) for haemodialysis and 77.9% (95% CI 73.8–81.9) for peritoneal dialysis. Supportive care patients had a 1-year survival of 70.6% (95% CI 63.3–78.0%). Residual heterogeneity remained within individual treatment modalities despite subgroup analyses. **Conclusions:** While the available literature demonstrates a broadly similar 1-year survival in elderly ESKD patients, it does not allow a confident estimate of the relative survival benefits of dialysis or supportive care. This uncertainty needs urgent attendance by further prospective data, which avoid bias and allow comparisons of quality of life and survival. **Süstemaatiline ülevaade hõlmab 89 uuringut vahemikus 1976-2014. Mitte ühtegi RCT ei ole leitud, enamus uuringutest olid retrospektiivsed. 6 uuringus oli võrreldud 1 aasta eulemust dialüüsravil ja toetaval ravil patsientide vahel. Dialüüsravil olevatel haigetel 1 aasta elulemus on 84.2% (95% CI 73.5–94.8%) ja 72.7% toetava raviga haigetel (95% CI 64.2–81.2%). Kolm uuringut näitasid, et kaasuvate haigustega patsientide seas elulemus dialüüsravil vähenes. Ülevaate piirangud:**	**http://www.ncbi.nlm.nih.gov/pubmed/26265214**

väike toetaval ravil patsientide arv (724 pts), lead-time bias.

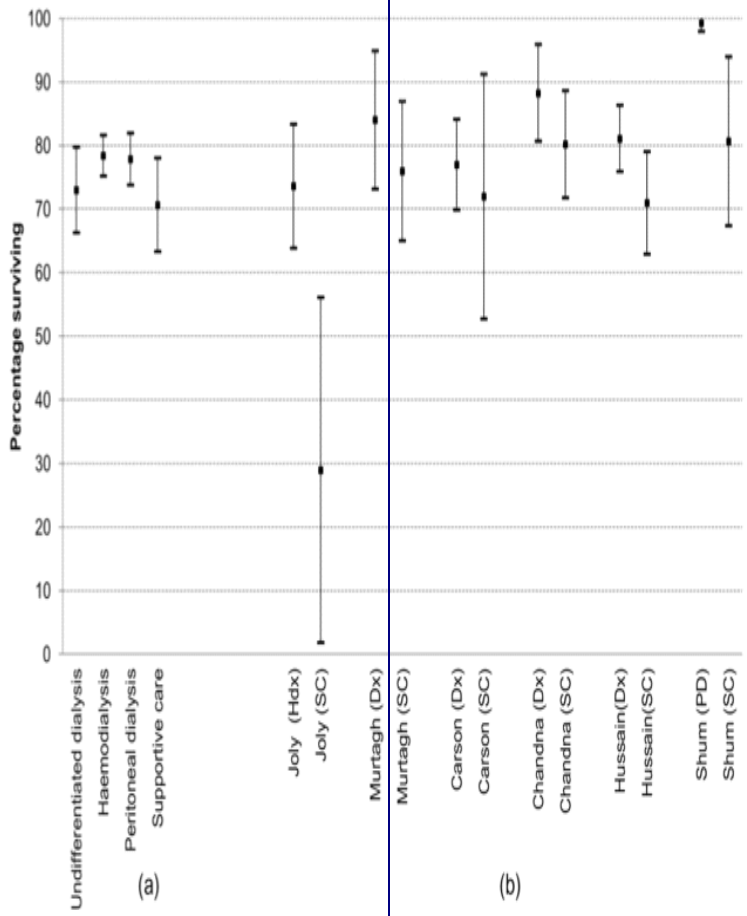

Fig. 4 Comparative 1-year survival (95% (confidence interval (CI)) of elderly patients treated with undifferentiated dialysis, haemodialysis, peritoneal dialysis and supportive care in (a) all studies and (b) in studies directly comparing survival for supportive (non-dialysis) and dialysis management. Individual study characteristics are listed in Table 1.

3. Mario Pacilio et al. Stage 5-CKD under nephrology care: to dialyze or not to dialyze, that is the question (2015). J Nephrol
DOI 10.1007/s40620-015-0243-8

http://www.ncbi.nlm.nih.gov/pubmed/26584810

Abstract:

Appropriate timing of starting chronic dialysis in patients with advanced chronic kidney disease (CKD) under nephrology care still is undefined. We systematically reviewed the most recent studies that have compared outcomes of stage 5-CKD under conservative versus substitutive treatment. Eleven studies, most in elderly patients, were identified. Results indicate no advantage of dialysis over conservative management in terms of survival, hospitalization or quality of life. Our systematic analysis of the literature highlight the need for further studies, not limited exclusively to elderly patients, to verify the efficacy

of non-dialysis treatment in stage 5-CKD patients. Meanwhile, nephrologists may consider that their intervention can safely prolong for several years the dialysis-free condition in ESRD independently of age. These findings therefore highlight the possibility of safely delaying RRT in advanced CKD by careful nephrology care in very ill patients as well as in those very old.

Table 1 Studies in the last decade comparing outcomes of stage 5-CKD patients under conservative versus dialysis treatment

References	Design/setting	Outcome	Sample	Age (years)	eGFR	CVD (%)	DM (%)	FU (months)	Main findings
Randomized									
Brunori [6]	VLPD vs. dialysis in elderly	Mortality, hospitalization	VLPD: 56 Dialysis: 56	79.3 ± 6.4 76.8 ± 4.3	5–7	68[a] 60[a]	None	27	VLPD postpones dialysis with no higher mortality or hospitalization
Cooper [7]	Early vs. late dialysis start	Mortality, adverse events	Early: 404 Late: 424	60.2 ± 12.8 60.5 ± 12.3	10–14 5–7	39.6[a] 38.2[a]	42.6 43.2	43	Similar mortality and adverse event rates
Observational									
Murtagh [8]	Retrospective in elderly; CM vs. dialysis	Survival	CM: 77 Dialysis: 52	83.0 79.6	<15	NA	25.0 23.4	24	In dialysis, survival advantage that is lost if high comorbidity
Carson [9]	Retrospective; CM vs. dialysis	Survival and hospitalization	CM: 29 HD: 173	83 75	<10.8 NA	NA	14.0 29.0	50	Unadjusted survival and hospitalization greater in HD
Chandna [10]	Retrospective; CM vs. dialysis.	Survival	CM: 155 Dialysis: 689	77.5 ± 7.6 58.5 ± 15.0	13.2 13.2	NA	35.5 34.3	55	Adjusted survival similar in the two groups
Da Silva [11]	Prospective; CM vs. dialysis	Survival, quality of life	CM: 30 HD: 80 PD: 44	77.5 ± 6.5 60.6 ± 14.9 48.0 ± 15.6	13.3 14.2 14.3	NA	NA	36	Similar adjusted survival and quality of life
Seow [12]	Prospective; CM vs. dialysis in elderly or high comorbidity pts	Quality of life	CM: 63 Dialysis: 38	78 71	10 10	NA	60.3 84.2	24	In dialysis quality of life not better in elderly and/or high comorbidity burden
Hussain [13]	Retrospective; CM vs. dialysis in elderly	Survival	CM: 172 Dialysis: 269	>70	<20	NA	NA	NA	In dialysis survival advantage lost for pts over 80 y or with high comorbidity
Shum [14]	Retrospective; CM vs. PD in elderly	Survival, hospitalization	CM: 42 PD: 157	75.3 ± 5.7 73.4 ± 5.3	6.8 6.3	75 71	67 53	24	In PD, lower hospitalization and longer survival, lost if comorbidity burden is high
Crews [15]	Retrospective; early vs. late dialysis start	Survival	Early: 146 Late: 80	65.7 ± 13.7 63.5 ± 15.4	≥10 <10	50.1[b] 38.8[b]	41.1 50.0	52	No difference in adjusted survival
Shih [16]	Retrospective; CM vs. dialysis in elderly	Survival	CM: 2049 Dialysis: 6292	82.0 ± 6.4 78.6 ± 7.1	<15	NA	35.1 37.3	32	Dialysis associated with shorter survival vs. CM

2015 aastal publitseeritud artikkel, artiklis on süstemaatiline ülevaade NAR vs konseravtiivse ravi kohta ning lisaks ka üks haigusjuht. Ülevaade hõlmab 11 uuringut, 2 neist on RCT. Üks RCT (DODE – The Diet or Dialysis) näitas, et valguvaese dieediga eakal lõppstaadiumi NP haigel võib dialüüsravi edasi lükata ~1 aasta võrra. Teine RCT – IDEAL, NAR alustamise kohta. Üheksa uuringut on ülevaatlikud uuringud, nende tulemused on sarnased: dialüüsiravil haigete elulemus on parem, kuid paljude kaasuvate haigustega haigetel elulemus dialüüsravil oluliselt väheneb, kahes uurngus on näidatud, et ka kõrgem vanus halvendab oluliselt prognoosi dialüüsravi patsientidel. Ainult ühes uuringus (Shih et al.) leiti, et dialüüsravi on seotud halvema prognoosiga sõltumata soost, kasuvatest

haigustest ja east.	
4. Mi-Kyung Song. Quality of Life of Patients with Advanced Chronic Kidney Disease Receiving Conservative Care without Dialysis. Seminars in Dialysis—Vol 29, No 2 (March–April) 2016 pp. 165–169 **Abstract:** With the evidence that dialysis may not necessarily be beneficial for older adults with advanced chronic kidney disease (CKD), there is a growing interest in promoting conservative care without dialysis as a viable treatment option for these individuals. This review summarizes the current empirical evidence of symptom experiences and quality of life of patients receiving conservative care. Data suggest that conservative care may yield symptom experiences and quality of life that are compatible with those of patients on dialysis. However, these data are exclusively from studies conducted outside of the United States in which there were often no comparison groups or study designs that could provide high quality evidence. There is an urgent need for further research and developing a conservative care model suitable for CKD populations in the U.S. **Ülevaade sümptomite esinemisest ja elukvaliteedist konservatiivse ravi korral.** **Sümptomid: paljudes uuringutes näidatud, et sümptomite esinemine on sarnane nii dialüüsravi kui ka konservatiivsel ravil patsientidel. Peab võtma arvesse, et dialüüsihaiged on nooremad ning neil on vähem kaasuvaid haigusi.** **Elukvaliteet: dialüüsravil haiged olid nooremad ja neil oli vähem kaasuvaid haigusi. Elukvaliteet oli parem dialüüsihaigetel, kuid vaimne tervis oli sama või isegi parem konservatiivsel ravil haigetel.** **Ühes uuringus seostati ka paremat elukvaliteeti parema sotsiaalse toega (teised dialüüsihaiged, med. personal).** **Patsiendipoolsed faktorid, mis mängivad rolli ravi valikul: sümptomaatilist ravi valivad enamasti vanemad, plajude kaasuvate haigustega patsiendid, need, kellel ei ole võimalust NARiks nt. elavad hooldekodudes.**	**http://onlinelibrary.wiley.com/doi/10.1111/sdi.12472/pdf** **täisteks lisatud PDF failina**
5. Sarah Tonkin-Crine et al. Understanding by Older Patients of Dialysis and Conservative Management for Chronic Kidney Failure. AJKD DOI: 10.1053/j.ajkd.2014.08.011 **Abstract:**	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4339698/

Background: Older adults with chronic kidney disease stage 5 may be offered a choice between dialysis and conservative management. Few studies have explored patients' reasons for choosing conservative management and none have compared the views of those who have chosen different treatments across renal units. **Study Design:** Qualitative study with semistructured interviews. **Settings & Participants:** Patients 75 years or older recruited from 9 renal units. Units were chosen to reflect variation in the scale of delivery of conservative management. **Methodology:** Semistructured interviews audiorecorded and transcribed verbatim. **Analytical Approach:** Data	
were analyzed using thematic analysis. **Results:** 42 interviews were completed, 4 to 6 per renal unit. Patients were sampled from those receiving dialysis, those preparing for dialysis, and those choosing conservative management. 14 patients in each group were interviewed. Patients who had chosen different treatments held varying beliefs about what dialysis could offer. The information that patients reported receiving from clinical staff differed between units. Patients from units with a more established conservative management pathway were more aware of conservative management, less often believed that dialysis would guarantee longevity, and more often had discussed the future with staff. Some patients receiving conservative management reported that they would have dialysis if they became unwell in the future, indicating the conditional nature of their decision. **Limitations:** Recruitment of older adults with frailty and comorbid conditions was difficult and therefore transferability of findings to this population is limited. **Conclusions:** Older adults with chronic kidney disease stage 5 who have chosen different treatment options have contrasting beliefs about the likely outcomes of dialysis for those who are influenced by information provided by renal units. Supporting renal staff in discussing conservative management as a valid alternative to dialysis for a subset of patients will aid informed decision making. There is a need for better evidence about conservative management to support shared decision making for older people with chronic kidney failure. **Uuringu eesmärgiks oli välja selgitada patsiendipoolseid põhjusi NAR valikul. Vestlus 42 patsiendiga erinevatest**	

dialüüsravikeskustest. Patsiendid: dialüüsravil (14 patsienti), ettevalmistus dialüüsraviks (14 patsienti), need, kes valisid konservatiivset ravi (14 patsienti). Konservatiivsel ravil patsiendid keeldusid dialüüsist: liiga kõrge vanuses tõttu, hirm olla veelgi rohkem seotud haiglaga. Uurijate hinnangul konservatiivsema lähenemisega keskustes haiged suhtusid positiivsemalt dialüüsravisse. Haigete hinnangul suur mõju otsuse tegemisel oli med. personalil.	

Ravijuhendid

Kolmes ravijuhendis (KDIGO, NICE, KHA-CARI) leidub infot antud küsimuse kohta.

KDIGO CKD management (lk. 115, 118)

5.2: CARE OF THE PATIENT WITH PROGRESSIVE CKD

5.2.2: The multidisciplinary team should include or have access to dietary counseling, education and counseling about different RRT modalities, transplant options, vascular access surgery, and ethical, psychological, and social care. (Not Graded) lk. 115

Multidistsiplinaarse meeskonna töö peaks sisaldama dieedinõustamist, õpet ja nõustamist NAR einevate võimaluste kohta, siirdamise, veretee kohta; samuti eetilist, psühholoogilist ja sotsiaalset tuge.

5.4: STRUCTURE AND PROCESS OF COMPREHENSIVE CONSERVATIVE MANAGEMENT

- 5.4.1: Conservative management should be an option in people who choose not to pursue RRT and this should be supported by a comprehensive management program. (Not Graded)

- Konservatiivne ravi peaks olema üks võimalus inimestel, kes valib mitte jätkata NARga ning seda peaks toetama kompleksne programm.

- 5.4.2: All CKD programs and care providers should be able to deliver advance care planning for people with a recognized need for end-of-life care, including those people undergoing conservative kidney care. (Not Graded)

- Kõik KNH programmid ja osutajad peaksid olema võimelised planeerima ‘end-of-life care’, kkasarvatud inimestele, kes läheb üle konservatiivsele neeruasendusravile.

- 5.4.3: Coordinated end-of-life care should be available to people and families through either primary care or specialist care as local circumstances dictate. (Not Graded)

- Kooskõlastatud ‘end-of-life care’ peaks olema kättesaadav patsientidele ja nende peredele kas esmatasandi või spetsialisti tasemel.

NICE CKD guideline

8.1.6 Recommendations

- **When developing information or education programmes, involve people with CKD in their development from the outset. The following topics are suggested.**

- ***Õpeprogrammide arendamisel kaasa KNHga inimesi. Järgmised teemad on soovitatud.***

Kui asjakohane info on vajalik NARi ja selleks ettevalmistamise kohta.

Konservatiivse ravi ja selle näidustused.

o What is CKD and how does it affect people?

o What questions should people ask about their kidneys?

o What treatments are available for CKD, what are their advantages and disadvantages and what complications or side effects may occur as a result of treatment/medication?

o What can people do to manage and influence their own condition?
o In what ways could CKD and its treatment affect people's daily life, social activities, work

o opportunities and financial situation, including benefits and allowances available?

o How can people cope with and adjust to CKD and what sources of psychological support are available?

o **When appropriate, offer information about renal replacement therapy (such as the frequency and length of time of dialysis treatment sessions or exchanges and pre-emptive transplantation) and the preparation required (such as having a fistula or peritoneal catheter).**

o **Conservative management and when it may be considered. [2008]**

KHA-CARI Guideline: infot ei leidu

KHA-CARI Acceptance onto Dialysis Guidelines, Predialysis education(2005) http://www.cari.org.au/Dialysis/dialysis%20acceptance/Predialysis_education_aug-2005.pdf:
Patients and their families or carers should receive sufficient information and education regarding the nature of end stage kidney disease (ESKD), and the options for the treatment to allow them to make an informed decision about the management of their ESKD (Level III evidence).
Patsiendid ja nende pered või hooldajad peaks saama piisavat informatsiooni lõppstaadiumi KNH kohta ning infot ja õpet ravi võimaluste kohta, et teha informeeritud otsust käsitluse kohta.

KHA-CARI Acceptance onto Dialysis Guidelines, Ethical considerations(2010) http://www.cari.org.au/Dialysis/dialysis%20acceptance/Ethical_considerations.pdf

(Suggestions are based on Level III and IV evidence)

• As dialysis is an accepted and available mode of treatment for end-stage kidney disease (ESKD) in Australia and New Zealand, the decision concerning acceptance onto a dialysis programme should be made on the basis of the patient's need. The cardinal factor for acceptance onto dialysis or continuation of dialysis is whether dialysis is likely to be of benefit to the patient.

- Peamiseks faktoriks dialüüsravi alustamiseks või jätkamiseks on kasu patsiendile.

• The patient or their legally recognized guardian should give or refuse consent for dialysis.

- Patsient ise või temale seaduslikult määratud hooldaja peaks andma nõusoleku dialüüsraviks või sellest loobumiseks.

-

  • Anexpectation of survival with anacceptable quality of life is a useful starting point for recommending dialysis. When the patient and/or their guardian wish not to proceed to dialysis, supportive care should be offered or continued. Supportive care is a recognized option for patients with ESKD.

- Oodatud elulemus ja elukvaliteet on kasulik alguspunkt dialüüsravi soovitamiseks. Kui patsient või tema hooldaja soovib mitte jätkata dialüüsi, siis peaks jätkama toetava raviga. Toetav ravi on tunnistatud meetod lõppstaadiumi KNH puhul.

• Issues of accessibility to dialysis services, mode of dialysis and the risks and benefits must be discussed with the patient and caregivers. It is desirable that the choice of dialysis modality be a joint decision between the patient and the physician; however, patients are entitled to choose for themselves from the available and appropriate modes of dialysis. The patient is entitled to be informed whether the lack of availability of a dialysis modality is limiting their choice.

- Dialüüsi kättesaadavus, dialüüsi meetod, riskid ja kasud peavad olema arutatud patsiendi ja hooldajaga. Soovitav, et dialüüsi meetodi valik oleks ühine patsiendi ja arsti otsus. Kuigi patsiendil endal on õigus valida kättesaadav ja sobiv dialüüsi meetod. Patsiendil on õigus teada kas dialüüsi kättesaadavuse piirang piirab nende valikut.

• When health professionals express doubt as to whether a patient should be offered dialysis, the patient is entitled to receive a comprehensive re-evaluation or further opinions. Depending on the circumstances, this may include consultation with another nephrologist (of the patient's choice), and input from a psychiatrist, social worker, dialysis nurse, occupational therapist, physiotherapist, patient and minority group advocates.

- Kui arst kahtleb, kas dialüüsravi peaks olema näidustatud, patsiendil on õigus saada teist arvamust. Sõltuvalt olukorrast see võib koosneda teisest nefroloogist, psühhiaatrist, sotsiaaltöötajast, dialüüsi õest, füsioterapeudist, advokaadist.

KHA-CARI Acceptance onto Dialysis Guidelines, Quality of life (2010) http://www.cari.org.au/Dialysis/dialysis%20acceptance/Quality_of_life.pdf

(Suggestions are based on Level III and IV evidence)

• A discussion of the effect of dialysis on quality of life (QOL) should be included in the decision-making process for undertaking dialysis treatment.

Üheks arutelu osaks dialüüsravi kohta peaks olema dialüüsiravi mõju elukvaliteedile.

• The discussion should include effect on physical function, burden of treatment, and effect on family and social life. This is best accomplished by a multidisciplinary team of appropriate health professionals.

Arutelu peaks sisaldama infot mõju kohta füüsilisele tervisele, ravi koormusele, pere- ja keskkondlikule elule.

• Age alone should not be interpreted as being predictive of poorer QOL.

Üksinda vanus ei peaks olema tõlgendatud kui halvema prognoosi ennustav faktor.

• Poorer physical and mental health should be considered predictive of poorer QOL on dialysis.

Halvem füüsiline ja vaimne tervis peaksid ennustama halvemat elukvaliteeti dialüüsravil.

• No single QOL measure should be used to recommend acceptance or denial of dialysis.

Elukvaliteedi määramine üksinda ei tohiks olla aluseks dialüüsravi valiku kasuks või põhjuseks sellest loobumiseks. ?

Malaysia CKD management: infot ei ole

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