End-of-Life Care for Patients Afflicted with Incurable Malignancy and End-Stage Renal Disease

End-stage renal failure (ESRD) patients (even without associated malignancy) have a high mortality and morbidity. As per the US Renal Data System (USRDS), the annual crude mortality is approx 20%.[1] The added presence of incurable malignancy definitely worsens the clinical outcomes in terms of quality of life, morbidity and mortality. Hence the utility (or otherwise) of initiating/continuing dialysis must always be assessed in a holistic manner.[2] However, currently most nephrologists are not comfortable with the idea of either withholding or withdrawing dialysis in these clinical settings. A recent study amongst US nephrology fellows revealed that more than two-thirds of the respondents thought that a formal rotation in palliative care during fellowship would be useful.[3] It is in this context that the article by Jing *et al.* in the current issue of the Journal throws light on management of patients afflicted with incurable malignancy and ESRD requiring dialysis support therapy.[4] As highlighted by the authors these patients have multiple co-morbidities with poor nutrition accompanied by anxiety and depression. The prevalence of such cases in the population is on the rise. Not addressing the need of palliative care in these patients may in fact subsequently lead to tribulation for the patient and the family.[5]

The primary goal of palliative care is alleviation of suffering and improving the quality of life of both the patients and their families. Management of renal failure by peritoneal dialysis (PD), which can be conveniently performed both at home and in the hospice setting, is thus of great help. Delivering the usual optimal dialysis dose in these patients would have limited clinical benefits. Rather, the patient would benefit from the treatment of the various associated symptoms. One of the problems of renal failure is fluid overload which can lead to distressing dyspnea and/or orthopnea. This can be treated/prevented with fluid restriction, diuretics and PD with exchanges of hypertonic glucose solution. Even in cases where PD has been withdrawn, intermittent PD exchanges can easily be done when required to remove extra fluid for the relief of the patient. The other frequent problem in such patients is chronic pain. This can be treated with the various available medications (including opioids) with appropriate dosage adjustment for renal failure. Other symptoms like nausea, pruritus, etc., can also be treated with drugs. Sedatives may also be used as necessary. Unnecessary use of dialysis only increases the cost of health care without accrual of significant benefits to the patients, their families or the society as a whole. Hence universal screening of all ESRD patients for palliative care needs has now been proposed.[6] The time has come for nephrology teams to work in tandem with palliative care practitioners for the care of these patients.[7,8]

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