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Letter to Editor

End-Stage Renal Disease Care Options in the Elderly: The Ethics of Conservative vs Dialysis Care

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More elderlies are facing End-Stage Renal Disease (ESRD) and physicians are continuously facing difficult choices regarding whether patients should be candidates for dialysis or for supportive care instead. A review of the literature shows that the mortality rate in dialysis differs depending on the comorbidities and the age. In a French study of 2015, the survival probability of patients starting Hemodialysis (HD) and aged above 75 years of age was 71% at 1 year and 54% at 2 years in Europe, and 59 and 43%, respectively, in the United States [1]. A Portuguese study published in 2019 noted that the overall mortality at 6 months after starting dialysis for patients aged 65 years and above was 14% [2]. A review of the literature entitled "Kidney supportive care: an update of the current state of the art of palliative care in CKD patients" [3] and published in 2021 evaluated the annual mortality rate of patients on dialysis to be around 20-25% in the general population, approximately 38% for those aged 75 years or older and it may exceed 50% in fragile elderly patients. What was striking in this review was the number of patients who regretted dialysis (19%). Back in 2010, 10-15% of death occurred in the hemodialyzed population after withdrawing from dialysis [4]. This reflects the poor quality of life in elderlies on HD.

Some elderlies opt for conservative management when faced with ESRD. This includes careful attention to fluid balance, treatment of anemia, correction of acidosis and hyperkalemia, management of blood pressure and calcium/phosphorus metabolism [5]. Several studies showed that the survival advantage in HD is lost in elderlies [6,7]. With elderly patients, comorbidity (especially the presence of ischaemic heart disease) should, therefore, be a key consideration in the dialysis decision-making process. Primum non Nocere! How are we supposed to select elderlies fit for dialysis and others who will benefit more from supportive care? In 1991, the Institute of Medicine Committee to Study the Medicare ESRD Program recommended the development of a clinical practice guideline because they noted there were "an increasing number of dialysis patients with limited survival possibilities and relatively poor quality of life." These guidelines were published in 2000 by the Renal Physicians Association and the American Society of Nephrology [8]. These guidelines insisted on the importance of establishing a good relationship between the physician and his patient for shared decision making. We should always explain to our patients (or their surrogate decision maker) their diagnosis, their prognosis, and the treatment options. As physicians, we should learn to avoid presenting treatment choice as binary. It's never do hemodialysis or nothing, or even worse do hemodialysis or die. The "surprise" question "Would I be surprised if this patient died in the next year?" can be used together with known risk factors for poor prognosis: age, comorbidities, severe malnutrition, and poor functional status to help orient the nephrologist [9]. If the benefit of hemodialysis treatment is uncertain, it is recommended to start a time-limited trial of the treatment and then stopping it if the anticipated benefit does not occur. Patients approaching end stage kidney disease are willing to trade considerable life expectancy to reduce the burden and restrictions imposed by dialysis [10].

At the end of the day, we should always make sure we are not violating any of core principles of bioethics: respect for autonomy, beneficence, nonmaleficence, and justice. At the end of the day, it's about "cure sometimes, treat often, comfort always". (Hippocrates)

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