Dancing around Elephants

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Most nephrologists are now accepting that there are similar general clinical outcomes between hemodialysis (HD) and peritoneal dialysis (PD) patients. Patient selection had played a role in the different earlier versus later outcomes, but these cofounders are understood and reconciled, and they helped us conclude that, for clinical outcomes, these modalities are similar. Thus, the choice of therapy should depend on other aspects of an individual’s life circumstances. Is that what happens?

Prakash et al. (1), in this issue of CJASN, inform us that neighborhood socioeconomic status may influence specific barriers to PD choice but that, in general, PD eligibility and choice were not barriers. This well designed and thoughtfully executed study adjusted its insights as more knowledge was attained during the study’s course. Importantly, in the approach taken by the centers involved in this study, patients reported barriers to the use of PD, and those barriers were discussed internally to see if they could be addressed and overcome. Therefore, to the extent that patients verbalized barriers and that Ontario health insurance was available (>99%), the study seems solid, and the results seem valid. The health care providers described the following themes categorizing barriers to PD eligibility: medical condition, physical/social environment, medical procedures, functional limitations, cognitive/mental disorders, family/social support, self-management reasons, and others.

Although I think that much of this Canadian study is probably broadly applicable, there may be important international differences to consider. The patients in the study were in a universal coverage health care system structured to emphasize education about dialysis, particularly through a uniform process. Prakash et al. (1) suggest that the US renal community adopt such processes. Prakash et al. (1) and the works by Golper and Schreiber (6) are the consequences.

Using my approach and comparing it with the approaches of my contemporaries, I find that many more patients prefer home dialysis. When asked their preference if they were in need of dialysis, most of my support team generally respond that they would perform home dialysis. Thus, there is an emphasis on encouraging home dialysis when we perceive that it is feasible for that patient. The reason that I provided the modality status of my patients is that, in my experience, the major deciding factors of PD versus HD are the training time and dialysis partner availability. These features were included in the study by Prakash et al. (1) but did not seem to be as influential as they are in my practice. In our program, PD training takes about 1 week and is often done independently of a partner; in comparison, NxStage home HD (a unique simplified HD system requiring frequent dialysis) training takes 3 weeks, and more traditional home HD requires up to 8 weeks of training. For both forms of home HD, the availability of a partner is preferred but individualized.

Medicare payments clearly incentivize home dialysis in the United States. Since the prospective payment system (Bundle) was implemented by the Centers for Medicare and Medicaid Services in 2011, home dialysis...
has grown in the United States (7). Systematic barriers exist for both PD and home HD (2,4), despite these financial incentives and publicized appeals for corrective actions. Prakash et al. (1) suggest targeting the identified barriers as a logical approach to increase the use of home dialysis (particularly PD). Frankly, I think that this approach is dancing around the elephants in the room.

Editorials are opinions. In my opinion, there are two elephants in the room of barriers: one large elephant and one smaller child of the large elephant. The child is the lack of infrastructure to promote PD. There are too few surgeons committed and trained to address the unique surgical problems of PD. A parallel statement can be made for PD nurses. There is no specific course for training dialysis nurses in PD care. Hospital dialysis unit nurses and/or ward nurses are often inadequately trained or equipped to care for PD patients. At Vanderbilt University Medical Center, we observe hospital-acquired peritonitis far too frequently. Emergency departments are used as peritonitis management centers and often lack specific protocols. The same is true for the microbiology laboratories that process samples inappropriately. Organizing a PD catheter placement requires complex planning compared with the two telephone calls that it takes to organize in-center HD. One call goes to interventional radiology to place a central venous catheter, and the second call goes to the in-center HD charge nurse with a brief set of dialysis orders. PD is more complicated, and systems to streamline its planning and initiation are too often inadequate.

However, the infrastructure deficiencies could and would be corrected by a larger group of PD-committed nephrologists. Nephrology certainly does not lack for energetic and creative problem-solvers. The infrastructure barriers comprise the small elephant, the child of the large elephant that is consuming the space in the room. This large elephant is the failure of US nephrology training programs to adequately prepare fellows for the practice of all forms of home dialysis. Ultimately, those fellows will become the committed nephrologists who tackle the infrastructure barriers by promoting surgical and nursing expertise. This deficiency has been well documented (8,9) and recently re-emphasized (2,3). Competency in PD is determined at the local level by the nephrology certificate (American Board of Internal Medicine [ABIM]; through Accreditation Council for Graduate Medical Education and the Residency Review Committee [RRC] of the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine [ABIM]; through the nephrology certification board exam) must be involved if training in home dialysis is to be strong enough to produce a generation of nephrologists with enthusiasm and knowledge of home dialysis. The ASN seems to be tertiary to the RRC and ABIM as regulators. However, I believe it is up to the ASN to apply the pressure needed to see this process through, such that patient choice truly is the decider on kidney replacement modality. In other words, stop dancing around the elephants; eliminate them.

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Disclosures

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