I appreciate the opportunity to comment on the article appearing in this issue of CJASN, titled “Medicare Bundled Payment Policy on Anemia Care, Major Adverse Cardiovascular Events, and Mortality among Adults Undergoing Hemodialysis,” by Park et al. (1). I have lived with CKD for 24 years. I experienced anemia before dialysis (while on chemotherapy for an autoimmune disorder), during peritoneal dialysis, and even now, after 23 years of a successful kidney transplant.

I was fortunate to start my kidney journey after the initiation of erythropoietin-stimulating agents (ESAs) and have never had a blood transfusion. However, from the onset of my kidney disease, I did experience chronic fluid overload. It was not until my kidney journey had led me to patient advocacy that I discovered the importance of fluid overload and its relationship with anemia. Sadly, many patients do not understand this topic well.

What patients do understand, however, is the decreased quality of life (QOL) they experience when they have anemia and do not feel like getting out of bed. I was lucky I was not subjected to a blood transfusion, which could have elevated my antibodies and created obstacles for my transplant over two decades ago. Before ESAs, anemia and fluid overload were challenges, and they still create debilitating obstacles for patients today.

I follow bulletin boards and hear the concerns about anemia from patients on dialysis. Patients become overwhelmed because they really need to be an active participant in their own health care and advocate for themselves, they do not have the energy to do it. Daily, I see how patients are concerned about their antibody levels when they have been told the levels are too high for a transplant. Receiving transfusions puts them in the predicament of possibly having antibodies that make it more difficult to receive a transplant. Patients do not understand why they show up for their treatments and still feel crummy, and are unable to pursue their life goals.

Some questions came to mind when reading this cohort study by Park et al. In the study, “Patients were excluded if they had a kidney transplant before hemodialysis or major adverse cardiovascular event … outcomes before day 91” (1). However, did the patients have an infection or comorbidity that may have affected their anemia or morbidity? Because they were hospitalized, were the patients newly diagnosed with kidney disease, or had they been medically managed for years? They had been admitted for 90 days, but what was their mobility?

A patient’s dry weight can affect hematocrit. If they are fluid overloaded and do not have the target dry weight assessed correctly, it will lead to anemia because they are volume overloaded. Fluid overload happens frequently because the patient is sick and not eating normally, which can cause them to lose weight. Dry weight is not re-evaluated until the patient is symptomatic or shows physical sign of fluid overload. When I reached this point, I was severely fluid overloaded, which makes me wonder if that is a cause of cardiovascular events. It would be prudent for the researchers to consider this in their next study.

There is real-time hematocrit monitoring that is available but underused. Due to fluid overload, is anemia being managed as well as thought? Because fluid overload also contributes to cardiovascular events, this variable blurs the cohort results. Having fluid overload causes cardiovascular risk.

When the bundle payment was first initiated to include ESAs, I was new to patient advocacy. During that time, I also learned about the “new” guideline from the US Food and Drug Administration about ESAs giving just enough to avoid a transfusion (2). Being an allied health care provider myself, I understood the science presented when hemoglobin levels were not <10, which increased cardiovascular events.

But these changes all happened in concert. Now by not giving ESAs, a profit was at stake, and my friends and I witnessed patients’ hemoglobin levels plummet. I suspect payment is driving the practice.

This started a trend of using different ways to treat anemia that were less costly. When the number of iron infusions increased, “Use of intravenous iron supplementation was relatively stable, but after January 2012, there was an immediate increase in the prevalence of iron use” (1). In my
experience, bowel impactions are common in patients living on dialysis. Did the increase in intravenous iron supplementation increase the number of bowel obstructions, infections, and hospitalizations? How did it affect the QOL of patients living on dialysis, and did it contribute to anemia?

Lastly, it was cited that after ESA usage was decreased, patients with anemia “were associated with lower risks of major adverse cardiovascular event, stroke, mortality, and heart failure but higher risk of acute myocardial infarction among adults receiving hemodialysis” (1). I must ask, has the pendulum swung too far the other way? Are patients who are receiving blood transfusions being overly exposed to other dangers: myocardial infarction, increased antibodies, and reduced QOL? Could our limited blood resources be better managed? Can we manage anemia more effectively if we utilize tools that are already available to manage fluid overload? I am thankful to Park et al. for addressing this important topic, and I hope this article inspires others to explore the additional questions I have asked.

Anemia is a debilitating illness, and all factors of how the patient is feeling should be part of the question to ensure patient-centered care is delivered and the patients can maintain their best QOL.

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