HOME HAEMODIALYSIS: A SINGLE CENTRE EXPERIENCE SINCE 2002 NICE GUIDELINES

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BACKGROUND: Home haemodialysis (HHD) continues to be used by only a minority of patients and the 2002 NICE guidelines recommending a major increase in the use of this modality. Despite initial higher costs of HHD due to set-up and training the 'pay back period' has been estimated as 14 months. We were interested in demographic data and outcomes in our HHD program after the publication these guidelines.

MATERIAL AND METHOD: We studied the prevalence rate, incidence rate, underlying renal disease, time spent on HHD and reasons for termination on a cohort of patients, following publication of the 2002 NICE guideline. Data was collected retrospectively from a dedicated renal database and case notes between the periods 01.01.2002 to 31.07.2007. Statistical analysis was done by SPSS.

RESULTS: We identified 47 patients, (36 male 11 female; 2 Asian, 45 Caucasian, mean age 49 years ± 12years) who successfully trained for HHD. Common underlying renal diseases were adult polycystic kidney disease (n=13), chronic glomerulonephritis (n=8), reflux nephropathy (n=7) and unknown (n=6). We have achieved a rise in the point prevalence from 6 patients in 2002 to 22 patients in 2006. The average number of new HHD patients was 8 per year (range 4-9 per year) and the average drop out was 5 per year (range 1 –8 per year). Mean training time was 2.6 months (range 1.4-8 months). 29 patients terminated treatment (* see graph below), (13 transplanted, 6 switch to centre HD, 8 died, 2 transferred to other centre) after a variable period of time. 65% of patients had HHD for 14 months or more (which is defined as the pay back period), 50 % achieved 29 months or more, and 30% 48 months or more before termination. 5 patients received a transplant within the first year.

CONCLUSION: We have successfully increased HHD patient numbers since the publication of the 2002 NICE guidelines. HHD remains an option for a minority of patients (6% of the haemodialysis population) but our data prove that a marked increase is feasible with a dedicated program with emphasis on counselling and efficient training. The high dropout rate remains a concern. Although the single most important reason for termination was transplantation, some of these transplants occurred early which may not offset the initial high cost. UK data from the 1990s suggest a break-even point of 14 months, a contemporary cost analysis of HHD in the UK is necessary and changes in transplant allocation may impact these data.
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