INTEGRATED CARE

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The existence of more than one treatment modality for patients with renal failure provides welcome opportunity for patients and their clinical carers alike. That these differing treatments may be linked together to provide a life time of renal replacement in many patients clearly makes practical sense. The concept of integrated care, however, intends to take this approach to therapy one stage further – it advocates, where appropriate, the active use of sequential modalities. From the patient's perspective, this means utilising the therapy at each stage, where possible, that is associated with the best clinical outcomes. In this context, a holistic view of patient health – one that includes psychosocial aspects, as advocated by the WHO, is central. Crude survival, although important, is not enough. Health status and individualised quality of life (QOL) are also measurable outcomes that are often more important to patients. From the perspective of those providing RRT, the aim is to deliver care in the most cost effective and responsible way, seeking to use each modality to its greatest advantage, whilst avoiding the disadvantages.

The best example of the successful integrated use of renal replacement treatments is the short-term use of dialysis to support successful transplantation, an approach that is supported by analyses of survival, health status, individualised QOL and cost effectiveness alike. It must also be recognised that for a substantial proportion of patients that hospital based HD, the default treatment, is the only realistic option. It this talk I will focus on two particular issues. First, I will examine the published literature to establish whether clinical outcomes support the use of sequential therapies following the initial therapy choice made by patients. Data from national registries, NECOSAD and single centre studies indicate that overall outcome is independent of initial modality. The dialysis modalities are not equivalent however, with differing impact on residual renal function and technique survival. There is strong but circumstantial evidence that patients using PD followed by HD can enjoy better outcomes than those using one therapy alone. There is, however a paradox. Switching treatment modality is associated with an increased early mortality and certainly considerable morbidity. For the second part of my talk I will focus on this particular problem, discussing why patients switch, the evidence for their increased mortality and whether an anticipation of problems can be used to manage this process more successfully. I will also discuss whether two particular concerns, anuria and sclerosing peritonitis should lead to automatic transfer from PD to HD. New data, for example from the European Automated Peritoneal Dialysis Outcome Study, would suggest that we can identify patients in whom problems are more likely to occur. Whereas single, severe episodes of peritonitis that result in permanent membrane damage are difficult to anticipate, regular monitoring of peritoneal membrane function, glucose exposure and achieved daily ultrafiltration will help the clinician to transfer the right patients while enabling those with low risk to remain on their treatment of choice.