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Key Points:

Abstract:

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Urgent Start Peritoneal Dialysis:
Let’s Ask the Patient

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In this issue of *Kidney 360*, Drs. Luciano, Ghaffari and Sanchez provide compelling arguments for and against the use of urgent start peritoneal dialysis (PD) to solve a critical issue; namely that up to 60% of patients with end-stage kidney disease (ESKD) do not have an established plan for kidney replacement therapy at the time they present with indications to start dialysis (1). The lack of this planning and the unanticipated progression of kidney disease leads to a majority of patients starting hemodialysis with a tunneled central venous catheter with suboptimal outcomes (2,3). These poor outcomes are not disputed. There is also the supposition that once a patient starts with in-center hemodialysis their awareness of other kidney replacement modalities remains limited and thus, changing modalities to a home therapy becomes much less likely. Urgent start PD is a clearly an alternative to the default practice of starting patients on hemodialysis with a catheter and has shown good outcomes in several studies while also having some concerns with an increased rate of complications such as catheter leaks (4,5). The debate highlights these issues in detail and clinicians should be familiar with these data.

In the end, our goal as nephrologists and patient advocates is to find the right kidney replacement therapy for each patient taking into account the myriad of individual factors that influence this choice. Such factors include (but are not limited to): space for storing peritoneal dialysis supplies, safe home environments, social support networks, patient dexterity and vision, transportation options and most importantly, personal values and preferences. In addition, access to newer enabling technologies such as remote patient monitoring and telemedicine may make home dialysis therapies more
accessible to some patients, broadening possibilities that previously might have been thought to be not possible (6).

In the end, when we are faced with therapies that have similar or nearly equivalent outcomes as with PD and in-center hemodialysis, we need to rely on robust programs that allow patients and families to make the best decision for themselves based upon the best evidence which is freely shared with them (7). Rather than chasing arbitrary goals for a percentage of patients on a particular dialysis therapy, we need to focus on the patient and family making the best choice for them. Shared decision making (SDM) is a key component of patient-centered health care and decision making. It is a process in which clinicians and patients work together to make decisions and select tests, treatments and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values. In fact, a single center program enrolled 108 patients using a model similar to SDM and using this approach 70% of patients chose a home dialysis modality with 55% choosing PD (8). Of note, three education sessions were needed to allow patients and families to make their preferred choices. This highlights the iterative and ongoing nature of this decision pathway and why typically such programs have not been used in more acute settings.

Regarding the urgent choice for dialysis modality, a shared decision process might consist of the following steps: (1) a realization that a decision needs to be made regarding what modality of dialysis is applied; (2) information is exchanged including benefits and harms and supplemented with evidence-based decision aids delivered by educators and patient advocates; (3) values and preferences of the patient and their
family are obtained along with input from care team; (4) an assessment of feasibility of treatment options is performed; (5) a preferred choice is reached and (6) a final decision made and implemented. Typically, shared decision making is best done in an outpatient setting where patients, families and providers have the time to work through these steps with deliberation and interaction. A more acute setting poses significant challenges but does not mean that the process should be abandoned. Such a process builds trust in future decision making and while challenging, a dedicated process can be developed to ensure engaged patient involvement in the decision whether it be urgent start PD or another route. Indeed, having dedicated professionals familiar with SDM as well as clear evidence-based decision aids (available in various languages and reading levels) makes this process easier and avoids have to “re-invent the wheel” every time such cases present themselves.

Lastly, it is important to note that patients must be educated regarding the spectrum of kidney replacement options. Given the complexities of life and changing health and social circumstances, a particular therapy may be most appropriate for a given time and place. But, situations and preferences change. The use of transitional care units also present an opportunity to address shortcomings in ESKD care especially in patients that had poor or little predialysis care (9). While no kidney replacement therapy is perfect, programs should have the ability and resources to offer patients ALL options for care. If not at a single site, then they should have access to resources at other sites to ensure that equity in options is available. Urgent start PD is an excellent option for appropriate patients and should be included in the portfolio of our kidney
replacement therapies. More importantly, SDM provides a critical framework to ensuring the right therapy is chosen with the greatest chance of success.

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**Author Contributions**

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References


