

Abstract

The interdisciplinary approach used in palliative care, which was established to satisfy the needs of patients with a life-threatening illness and their families, has drawn more attention in recent years. Most clinical realities still reserve palliative care for patients who are nearing the end of their lives, leading to confusion between hospice care and palliative care even though the modern concept of palliative simultaneous care postulates the adoption of these high-quality treatments early in the course of the life-threatening disease (and possibly just after the diagnosis). Patients with acute or chronic kidney disease (CKD) typically have a poor quality of life and a lower chance of survival; as a result, palliative care may be beneficial. In order to discuss the diagnosis, prognosis, practical treatment objectives, and treatment decisions, palliative care involves close collaboration between several healthcare professionals, patients, and their families. To fully address the demands of patients with kidney disease, a variety of strategies, including peritoneal palliative dialysis, extracorporeal, and conservative therapy, can be used (e.g., physical, social, psychological, or spiritual needs). Pharmacologic medication or peritoneal dialysis may be more suitable than extracorporeal therapy, especially for fragile patients. Treatment with extracorporeal dialysis may

Keywords: Palliative care; Chronic kidney disease; End-stage kidney disease; Acute kidney injury

Introduction

Multidisciplinary approaches used in palliative care are intended to assist doctors in caring for patients with life-threatening diseases [1, 2]. This cutting-edge viewpoint was created to acknowledge and address the requirements of patients with a life-threatening illness and their families. It is primarily based on a multidimensional analysis, which entails identifying and managing patients' physical, psychological, and social needs as well as their spiritual and social needs, evaluating patients' clinical conditions and prognoses to set appropriate and realistic treatment goals, creating individualised treatment plans in accordance with patients' preferences, paying attention to families' needs, and supporting healthcare professionals [2].

Patients who have had curative therapies deemed to have failed are now seen to be the most suited candidates for palliative care [1,3]. Because of this, the majority of healthcare professionals refer to palliative care as being synonymous with end-of-life care and beginning when life-prolonging therapies are stopped [3]. However, reserving palliative care until the very end of life may leave patients unable to manage their physical and emotional symptoms for the duration of their illness [3]. Nowadays, it is advised to provide both palliative care and life-sustaining therapies simultaneously to patients who are critically and non-critically sick, starting with those who have been diagnosed with a serious illness (such as cancer or chronic organ malfunction). Palliative care is neither an exclusive alternative to intense curative therapies nor a follow-up to vain attempts to extend patients' lives under this paradigm of simultaneous care [1,2]. All patients with a life-threatening disease might essentially receive simultaneous care, regardless of their age, comorbidities, or fragility. Instead, palliative care is suitable at any age, at any stage of a serious disease, and may be delivered in combination with curative therapy,

according to the definition created by the Center to Advance Palliative Care and the American Cancer Society. On the other hand, patients who get restorative therapy but forgo curative therapies and have an estimated lifespan of fewer than six months should receive end-of-life care [1,3]. Despite recent breakthroughs in treatment approaches, patients with acute kidney injury (AKI), chronic kidney disease (CKD), and notably end-stage kidney disease (ESKD) have shorter lives than people without kidney disease. The survival rates of these individuals can be improved using extracorporeal kidney replacement treatments (KRTs). The dying process for these individuals may be unnecessarily prolonged and made worse by these operations in some subgroups of acute, severely sick end-of-life patients [1].

The need for dialysis is rising gradually around the world, especially among older patients. Extracorporeal dialysis was used by 55% of patients with ESKD who were 65 years or older in 2005, as shown by the European Renal Association-European Dialysis and Transplant Association (ERA-EDTA) [4]. From 1980 to 2005, this number more than doubled. The majority of these patients receive KRT three times a week at an outpatient dialysis facility, necessitating frequent travel, which can be difficult for older and weak patients in particular [5,6].

These methods have been highly successful in extending life

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expectancy during ESKD thanks to technological advancements that characterise the maintenance of hemodialysis. Nevertheless, the high death rate for ESKD patients receiving maintenance hemodialysis, which is currently estimated at around 23% annually [1], is a result of the high incidence of other non-renal chronic disorders (mostly metabolic and/or cardiovascular comorbidities). A deterioration of physical, psychological, and social situations is also frequently seen within the first year after starting hemodialysis [1,6], in addition to a decrease of overall functional status. The maintenance hemodialysis-induced symptom load is equivalent to the symptom burden caused by chemotherapy for advanced cancer [1]. For these patients, palliative care should be taken into account. The use of proactive and early palliative care integration in the treatment of CKD patients has been shown to enhance patient outcomes. It's interesting to note that, especially in these extremely complicated diseases, only a multi-professional team can completely satisfy the patients demands. As a team, all doctors treating patients with severe CKD are urged to aggressively foster communication with patients and their families. These medical specialists, in accordance with their areas of specialisation and experience, are responsible for choosing the occasions, situations, and circumstances in which to begin the debate on renal maintenance replacement or palliative care. The nephrologist in particular is familiar with the course of renal illness, and the doctor deals with primary requirements and palliative care while being aware of the socioeconomic, familial, and psychological circumstances that affect patients and their families.

There are other ways to meet the patients demands and enhance quality of life besides the dynamic KRT adjustment and ongoing discussion of its aims. A significant number of patients regret beginning extracorporeal therapies and choose conservative therapy of ESKD as a result after speaking with and agreeing with caregivers. Planning the right care management for patients with ESKD requires providing patients, their families, and caregivers with education, information, and support. Peritoneal dialysis (PD) and conservative therapy (see below) are two more treatment choices that should be thoroughly addressed and shared with patients, families, and carers. Palliative medicine should be taken into consideration for patients receiving KRT and those who are treated with conservative therapy in order to enhance their quality of life.

Hemodialysis is a common kind of therapy for ESKD kidney replacement. Kt/V, or the urea clearance normalised to total body urea, is typically used to quantify the appropriateness of the solute clearances in extracorporeal therapies. Given the connection between Kt/V and mortality in the past, this measurement has been employed to help tailor

Conclusion

Palliative care, which is sometimes mistaken with hospice care, is primarily targeted at all cases of patients with serious illnesses who are in the final phase of the condition. Early use of palliative care can improve quality of life and help families in all of the aforementioned instances. Palliative care, which is a well-defined concept specifically for CKD rather than AKI, might assist renal patients because they often have a shorter life expectancy. In fact, many treatment approaches, such as palliative dialysis, conservative care, and PD, can be followed to enhance the quality of life in CKD patients. Each of these treatments calls for close communication between medical staff, patients, and families. Each of these treatments calls for close communication between medical staff, patients, and families. All involved parties must agree on the prognosis, reasonable treatment objectives, and therapy choices. The literature contains few and insufficient information about the impact of palliative and hospice treatment for AKI patients. In order to implement knowledge and understanding of this understudied issue, methodological, ethical, and therapeutic efforts are required.

Acknowledgement

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Conflicts of Interest

Author declares no conflict of interest.

References

1. Villa G, Samoni S, Maggio PD (2015) Palliative care for nephropathic patients. *Palliat Med Hosp Care Open J* 1: 16-23.
2. Aslakson RA, Curtis JR, Nelson JE (2014) The changing role of palliative care in the ICU. *Crit Care Med* 42: 2418.
3. Parikh R, Kirch R, Smith T, Temel J (2013) Early specialty palliative care-Translating data in oncology into practice. *N Engl J Med* 369: 2347-2351.
4. Romano T, Palomba H (2014) Palliative Dialysis: A Change of Perspective. *J Clin Med Res* 6: 234-238.
5. Kalantar-Zadeh K, Wightman A, Solomon Liao S (2020) Ensuring Choice for People with Kidney Failure-Dialysis, Supportive Care, and Hope. *N Engl J Med* 383: 99-101.
6. Kurella Tamura M, Covinsky K, Chertow G, Yaffe K, Landefeld C, et al. (2009) Functional status of elderly adults before and after initiation of dialysis. *N Engl J Med* 361: 1539-1547.
7. Uchino S (2005) Beginning and Ending Supportive Therapy for the Kidney (BEST Kidney) Investigators: Acute renal failure in critically ill patients: A multinational, multicenter study. *JAMA* 294:813-818.
8. Hartog CS, Peschel I, Schwarzkopf D, Curtis JR, Westermann I (2014) Are written advance directives helpful to guide end-of-life therapy in the intensive care unit? A retrospective matched-cohort study. *J Crit Care* 29: 128-133.
9. Villa G, Amass T, Giua R, Lanini I, Chelazzi C, et al. (2020) Validation of END-of-life ScorING-system to identify the dying patient: A prospective analysis. *BMC Anesthesiol* 20: 63.