Acceptance onto dialysis

CARI guidelines

The Caring for Australasians with Renal Impairment (CARI) guidelines initiative is an Australia/New Zealand evidence based project that aims to provide high quality, evidence based clinical practice guidelines for the management of all stages of kidney disease. This article summarises CARI guidelines on *Acceptance onto dialysis* and forms part of a series on aspects of assessment and management of patients with chronic kidney disease. Complete CARI guideline detail is available at www.cari.org.au. Accompanying expert commentary is by Dr Andy Lim.

Melissa Stanley
MN, BAppSc, is a nephrology nurse practitioner, St Vincent's Health, Melbourne, Victoria.
melissa.stanley@svhm.org.au

John Kelly
MBBS, MD, FRACP, is Staff Specialist in Nephrology, St George Hospital, Sydney, New South Wales.

David Harris
MD, BS, FRACP, is Professor of Medicine, and Associate Dean, Western Clinical School, University of Sydney, New South Wales.

Data sources

Medline, Embase, Cochrane Clinical Trials Database.

Study selection and assessment

No high level evidence (ie. systematic reviews of randomised controlled trials [RCTs] or standard RCT studies) was available. Recommendations were developed using evidence from observational studies such as cohort, case control and case series studies.

Suggestions for clinical care

Predialysis education

Patients and their families should receive: information from multidisciplinary nephrology clinics and structured education programs.

Level of renal function at which to initiate dialysis

Initiate dialysis when the glomerular filtration rate (GFR) falls below approximately 10 mL/min/1.73 m^2 with evidence of uraemia or complications such as malnutrition. Otherwise commence when GFR falls approximately below 6 mL/min/1.73 m^2. Monitor GFR quarterly from value 15–20 mL/min/1.73 m^2 and monthly from below 10 mL/min/1.73 m^2.

Other criteria for initiating dialysis

Dialysis should be initiated at the first indication of malnutrition suspected to be due to uraemia and unresponsive to dietary intervention or correction of other reversible causes. So called 'absolute indications' are no longer valid.

Mode of dialysis at initiation

Primary determinants of mode of dialysis include: patient preference, absence of medical and surgical contraindications, and resource availability. Otherwise consider using continuous ambulatory peritoneal dialysis, not automated peritoneal dialysis or haemodialysis, to better preserve residual renal function and allow graded introduction of dialysis. If using haemodialysis, use biocompatible rather than bio-incompatible membranes to better preserve residual renal function.

Expert commentary

Andy KH Lim
MBBS, FRACP, is a nephrologist, Monash University, Melbourne, Victoria.

The CARI guidelines highlight an insufficiency of strong evidence in the management of certain aspects of chronic kidney disease (CKD). For example, the ideal timing of dialysis initiation is still strongly debated. Some studies have raised the question as to whether early initiation of dialysis (GFR >10 mL/min) even in the absence of malnutrition or other evidence of uraemia, confer benefit. However, there have been no proper RCTs to date. The IDEAL (Initiating Dialysis Early And Late) trial, a multicentre prospective RCT involving Australian and New Zealand centres, hopes to address this uncertainty by comparing the outcomes of commencing dialysis at GFR 10–14 versus 5–7 mL/min/1.73 m^2. The results will hopefully be available by 2009.

It needs to be emphasised that pre-end stage kidney disease (ESKD) care is of utmost importance, as evidenced by the increased morbidity and mortality associated with late referrals to nephrologists. Although predialysis education is one component of this, timely referral may improve management of the metabolic derangements and the increased cardiovascular risk associated with ESKD and dialysis access creation. Late referral may be due to general practitioners being unaware of the severity of CKD or having reservations about the appropriateness of dialysis. Although the routine reporting of eGFR allows staging of CKD, should all patients be referred regardless of age, comorbidity or life expectancy? Unfortunately, the guidelines here do not address issues related to timing and indications for referral, and patient selection (as opposed to the selection of dialysis modality). These issues may prove challenging, even for experienced GPs. The final decision is the mode of dialysis, which I suspect is not an issue of great burden for GPs. Where doubt exists, an opinion from a nephrology colleague could be useful.

afp CORRESPONDENCE email: afp@racgp.org.au