

Kidney Care and Depression

A Patient's Perspective on the Challenges of Chronic Kidney Disease

By James "Mike" Guffey

I am not sure there is a good way to start dialysis, but I am certain that crashing into it is not the way to go. These impressions had nothing to do with the quality of care I received but reveal how overwhelming and impersonal the experience was, especially considering I was not functioning at top level when the situation began.

In one morning, I went from being on vacation away from home, thinking I had the flu while recovering from bronchitis and altitude sickness, to being admitted to the intensive care unit (ICU) with kidney failure.

How long have you had kidney issues? Is there a history of kidney disease in your family? How long have you been diabetic? Is there a history of diabetes in your family? Are your blood platelets usually this low? Is your BP always this high? How long have you had this edema in your legs? Have you been diagnosed with hepatitis? Do we need to test your blood for HIV?

These and many more questions like them greeted me in rapid fire in the emergency room. I barely got the chance to answer one before the next one came, with no chance to really process what was being asked. It was like being on the receiving end of a firehose as the team attempted to cover my entire medical history as quickly as possible. After all of the questions had been answered and I was admitted to the ICU, the situation did not greatly improve. The questions were replaced with an overflow of information.

What you have is officially called ESRD. Don't worry, that is just a classification used for insurance

and treatment purposes. It might be acute and go away over time, or it might be chronic. We are going to take you to surgery in a few minutes to get you a catheter in your chest so you can start dialysis as soon as possible. We will also be putting you on a renal diet.

End stage does not sound good. That sounds terminal. Catheter? Dialysis? Can we slow this down so I can understand what you are talking about? It is my life and my body, and I am feeling totally overwhelmed and don't know how I will explain the situation to my family and close friends.

That afternoon, I was whisked away for catheter surgery and back to the ICU for an initial dialysis treatment. The next morning, I was having what seemed a great breakfast with bananas and strawberries. Then, the dialysis technician walked in, saw what I was eating, and took it away! The hospital had me on the heart-friendly diet and not the renal diet, and I had no clue what the difference was. I felt bad about eating the wrong thing, but I didn't know what the right thing was. This drove home the idea that a lot was changing, and I had a lot to learn to succeed in my new circumstances.

There were lots of things to learn quickly, and there were initially no documents I could read on my own time, nowhere I could go to look for answers to my own questions. Slowly, I got some of the answers from visitors (the dialysis technician, the nephrologist, the dietician), and materials started to trickle in. Over the next few days, I began to feel a little more comfortable with the hospital treatment.

Then, the next stage of feeling overwhelmed set

in. There was a lot I needed to figure out before I was released. How soon could I go home? How would I be able to bathe myself every day without getting the catheter site wet? Where would I dialyze when I got home? Would I be cleared to work? (And if cleared, would I be able to work?) These were all major questions without immediate answers, and all needed to be resolved quickly. It was hard not to again feel powerless, overwhelmed, and depressed.

Thankfully, over time, the answers did come, including good information about websites I could visit to get my questions answered plus many that I did not know I had. I also was fortunate to have a good support team who helped me negotiate my way back home and back to work.

It is important to realize that there are two very different life changes that come with crashing into dialysis. The first is physical: adjusting to the requirements and potential limitations of life on dialysis—the fluid restrictions, the renal diet, the treatments, and their effect on your body. The second is psychological: finding ways to avoid allowing all of the physical changes to overwhelm you and drag you into depression. Although it is natural to feel overwhelmed when experiencing a major life change, such as ESRD, it is important to find ways to cope and not to fall into anxiety and/or depression. It is important to remember that, although there are parts of your lifestyle that are beyond your control, you can control how you respond and not let the situation control you. ●

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Screening for and Treating Depression in Patients with Chronic Kidney Disease

By Nicole C. Allen and Philip R. Muskin

Approximately one in five women and one in 10 men will suffer from depression over the course of their lives (1). Chronic illness generally confers an even greater risk for depression. Patients with chronic kidney disease (CKD) and in particular, those who are on hemodialysis (HD) are at a relatively high risk for depression. It is difficult to determine the exact rate of major depressive disorder (MDD) in patients with CKD because the somatic symptoms of depression are similar to the symptoms of uremia (e.g., decreases in appetite, energy, sexual interest, and sleep). Aches and pains are common in patients with CKD, patients on HD, and patients with MDD.

Depression is thought to be the most common psychiatric abnormality in HD patients, with the prevalence likely between 5% and 10% (2). Depression in patients on HD can stem from the variety of losses that these patients suffer, including loss of kidney function, employment, physical strength, and social function (3). Patients on HD with MDD are twice as likely to die or require hospitalization within a year as those without depression (4). The suicide rate in ESRD patients is also higher than that of the general population (5). Recently, the Cent-

ers for Medicare & Medicaid Services added a new requirement in its Quality Incentive Program to screen and follow up as indicated for depression in all patients 12 years of age and older with CKD on HD. The Centers for Medicare & Medicaid Services Quality Incentive Program does not require use of a specific screening tool, and it does not define which member of the care team must do the screening. Identifying and appropriately treating MDD can have an extraordinary effect on quality of life for patients with CKD.

Generally, it makes sense to screen for depression anyone who looks unhappy, bearing in mind that not everyone who looks unhappy has a psychiatric disorder. It is important to differentiate between MDD and an appropriate sad reaction to a difficult life situation, because the therapeutic approach will be different. Patients who have just received a difficult diagnosis or who have had a recent health crisis may be quite upset; however, this reaction often does not progress to MDD (i.e., a psychiatric disorder). People who are ill but not depressed will retain interest in things that have historically brought them joy. For example, a devoted Yankees fan who is chronically ill but not depressed may be sad, because he cannot stay

awake to watch a game on television; however, he will still be interested in the score. When that same patient seems completely uninterested in baseball season for days at a time, depression may be the culprit.

Any health care provider can do a basic screening for depression. To start, ask the patient how things are going and how he has been sleeping. Any patient who has had difficulty falling or staying asleep in the absence of difficulty breathing, frequent nighttime urination, pain, etc., should then be asked if he is feeling sad or blue and if he has lost interest or pleasure in things he usually finds fun. These two questions, each rated on a scale of zero to three over the last 2 weeks with zero being never and three being nearly every day, constitute the Patient Health Questionnaire-2 (PHQ-2). The PHQ-2 is a very brief, basic version of the more comprehensive PHQ-9, a nine-question screening tool commonly used to quickly assess for symptoms of depression (Figure 1). The PHQ-9 is available in many languages. A patient who scores three or more on the PHQ-2 should be asked to fill out a PHQ-9. The PHQ-2 has 97% sensitivity and 67% specificity in adults, whereas the PHQ-9 has 61% sensitivity and 94% specificity in adults (6). Almost 90%