

Use of Palliative Care Lags Among Minority Patients at the End of Life

Use of palliative care among patients with end stage renal disease (ESRD) has increased steadily since 2004, but use among minority patients lags behind whites, according to a study presented at Kidney Week 2016.

Palliative care, which focuses on comfort measures and may include discontinuing dialysis, may ease the burden for patients with ESRD who are nearing the end of life. To help ensure that patients are advised about the option of palliative care, the Centers for Medicare & Medicaid Services included voluntary end-of-life counseling in the 2016 physician fee schedule, wrote lead author Haytham Alkhalimy, MD, of Augusta (Georgia) University and his colleagues in their abstract.

“In medicine, unfortunately we sometimes prolong suffering,” said Alkhalimy. “We shouldn’t be shy about talking about palliative care at some point.”

Alkhalimy and his colleagues analyzed all deaths of patients receiving dialysis between 2004 and 2011 in the United States Renal Data System (USRDS) to see how many received palliative care or discontinued dialysis at least 4 days before death. Among the 874,777 patients who initiated dialysis during that period, 52% had died by the end of 2012.

Use of palliative care increased from 4% to 20% of dialysis patients in the database between 2004 and 2011, according to the analysis. “This is good news,” Alkhalimy said. “We have been using palliative care more.”

Patients who received palliative care were significantly more likely to be older at the start of dialysis (72±12 vs. 67±14 years). Women made up 47% of the palliative care patients vs. 44% of nonpalliative care patients.

Patients who had more hospitalizations were also more likely to receive palliative care (RR 1.04), likely because these patients had exposure to more physicians or to hospitals with palliative care units, suggested Alkhalimy.

Palliative care did not appear to hasten death, as there was no significant difference in the time to death between the two groups.

“If you go into palliative care you may think your life will be shorter, but this shows it will be the same,” Alkhalimy said. The analysis included all patients who had a palliative care code under ICD9, he said. Some may have continued dialysis while receiving palliative care, which may have prolonged life.

Patients whose causes of death were coded as cardiac, gastrointestinal, metabolic, vascular, or infection-related were less likely to receive palliative care. “If you have a heart attack or something immediate there may not be time to go into palliative care,” Alkhalimy explained.

There were also significant differences between the use of palliative care by minority patients and white patients. About 80% of the patients receiving palliative care were white, 17% were black, and only 3% were from other minority groups.

The study could not explain the reasons behind the differences in palliative care utilization between groups, noted Alkhalimy. He said there is a need for more studies, including prospective studies, about the use of palliative care to help understand its use in patients with ESRD.

There are likely multiple factors that might contribute to disparities in the use of palliative care, said L. Ebony Boulware, MD, MPH, chief of the division of general internal medicine at Duke University

School of Medicine.

“Evidence shows that there are differences in patient preferences, patient-provider communication, education, and lack of trust among minorities, all of which could influence receipt and use of palliative care,” Boulware said.

Studies aimed at understanding patient, provider, and system level factors that influence use of palliative care in dialysis patients are warranted, she said. In particular, identifying barriers to palliative care, especially for minorities, might help explain the patterns identified in the study.

“Efforts to educate patients as well as providers and to make both aware of the role of palliative care in the context of dialysis may be critically needed,” Boulware said.

In the meantime, Alkhalimy suggested that clinicians educate themselves about palliative care so they can discuss the option with patients who might benefit. He acknowledged that end-of-life care options are a difficult topic to discuss, which may cause physicians to hesitate.

“You don’t want to be uncomfortable,” he said. “You don’t want the patient to be uncomfortable.”

But he noted that if a patient is nearing the end of life and has a poor quality of life as a result of dialysis or other treatments, failing to discuss palliative care may prolong their suffering.

“Palliative care is sometimes needed for comfort measures and to improve a patient’s quality of life,” he said. ●

“Racial Disparities in the Utilization of Palliative Care in Dialysis Patients from the United States Renal Data System” (Abstract 4963)

Poor Sleep Increases Kidney Failure Risk

Chicago—Too little and poor quality sleep are associated with a greater risk of kidney failure, according to results from the Chronic Renal Insufficiency Cohort Study (CRIC) presented at Kidney Week 2016.

While sleep disorders are common in patients with chronic kidney disease (CKD), how poor sleep may affect disease progression is not clear, according to the study’s lead author Ana C. Ricardo, MD, MPH, an assistant professor in the division of nephrology at the University of Illinois College of Medicine at Chicago.

So Ricardo and her colleagues conducted a prospective study of 432 adults enrolled in the CRIC study at 2 centers. The CRIC study is a longitudinal, multicenter study that has followed nearly 4000 people with CKD for several years. Participants in the sleep study wore a wrist activity monitor for 5–7 days to record their sleep duration and sleep quality. They also filled out questionnaires about their sleep quality, daytime sleepiness, and risk of sleep apnea. The participants were then followed for an average of 5 years during which 70 developed end stage renal disease (ESRD) and 48 died.

An average night of sleep for participants in the study was 6.5 hours, and about 1 in 5 participants experienced sleep interruptions. For every extra hour of sleep, the researchers found a 19% lower risk of developing ESRD when they controlled for several factors,

including body mass index, blood pressure, baseline kidney function and cardiovascular disease (HR 0.81, 95% CI 0.67–0.99 per hour increased sleep length). Patients who had more interrupted sleep also had increased risk of developing ESRD with a 4% increase in risk for every 1% increase in sleep fragmentation (HR 1.04, 95% CI 1.01–1.07 per 1% increase in sleep fragmentation). More fragmented sleep was also linked to declines in eGFR (-0.17 mL/min/1.73 m²/year, p=0.016).

“Short sleep and fragmented sleep are significant, yet unappreciated risk factors for CKD progression,” Ricardo said. “Our research adds to the accumulating knowledge regarding the importance of sleep on kidney function, and underscores the need to design and test clinical interventions to improve sleep habits in individuals with CKD.”

Earlier this year, another study that followed 4238 participants in the Nurses’ Health Study for 11 years found that nurses who reported sleeping less were at higher risk for more rapid declines in their estimated glomerular filtration rate (McMullan CJ, et al. *Kidney Int* 2016; 89:1324–1330).

While the previous study suggested a link between shorter sleep duration and earlier stages of CKD, the Ricardo study strengthens the evidence by linking sleep duration to ESRD, said Mark J. Sarnak, MD,

MS, Director of Research in the Division of Nephrology at Tufts Medical Center. The CRIC Study also used more objective measures of sleep duration and quality than the previous study.

How reduced or poor quality sleep might contribute to declining kidney function is less clear, Sarnak noted.

“A valid question is whether quantity or quality of sleep is a causal risk factor for kidney function decline or have we not sufficiently adjusted for covariates that may be associated with both poor sleep and kidney function decline,” Sarnak said.

Larger studies that adjust for such factors as well as additional mechanistic studies may help answer these questions and lay the groundwork for studies of potential interventions that improve sleep quality and slow progression of kidney disease, he said.

Although there is not yet enough evidence to definitively say that sleeping better will reduce the progression of kidney disease, there is sufficient evidence to show that sleep is important for overall health, Sarnak noted.

“Clinicians should be asking questions about sleep and educating patients about healthy sleep hygiene,” he said. ●

“The Association of Sleep Duration and Quality with Chronic Kidney Disease Progression” (Abstract 3754).