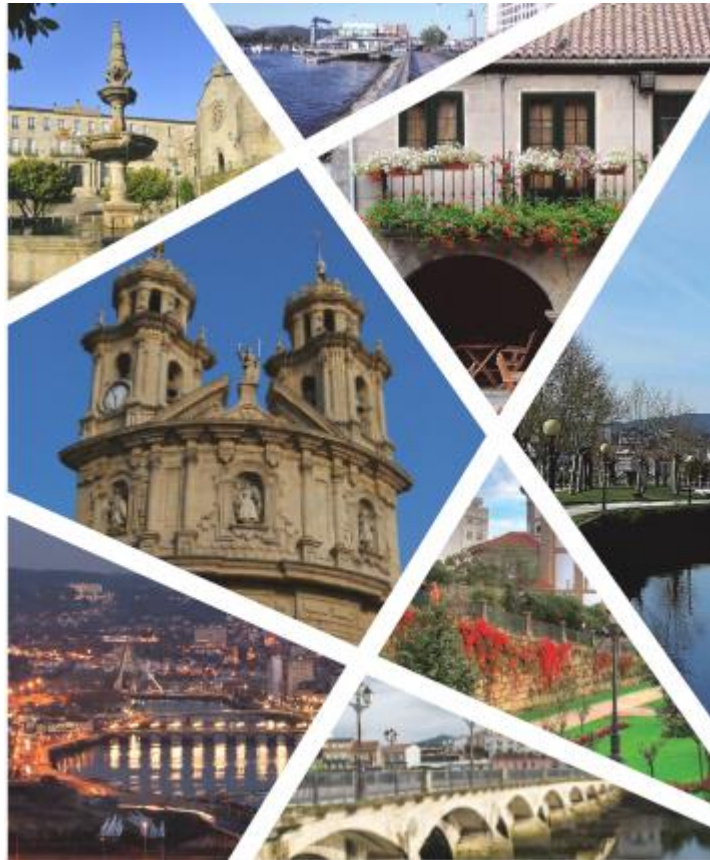


5º CONGRESO de la **SOCIEDAD GALLEGA de NEFROLOGÍA**

26 Y 27 DE OCTUBRE DE 2018

SEDE: AFUNDACIÓN, PONTEVEDRA

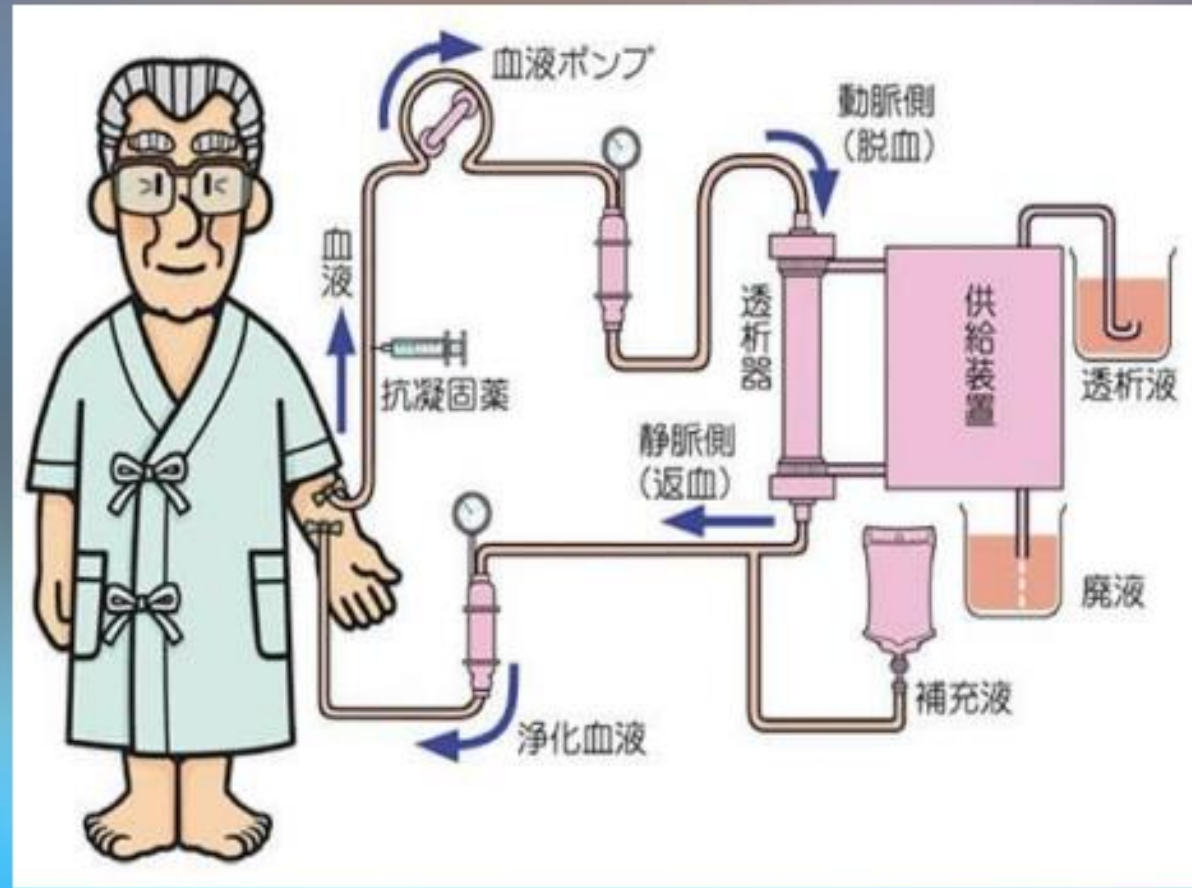
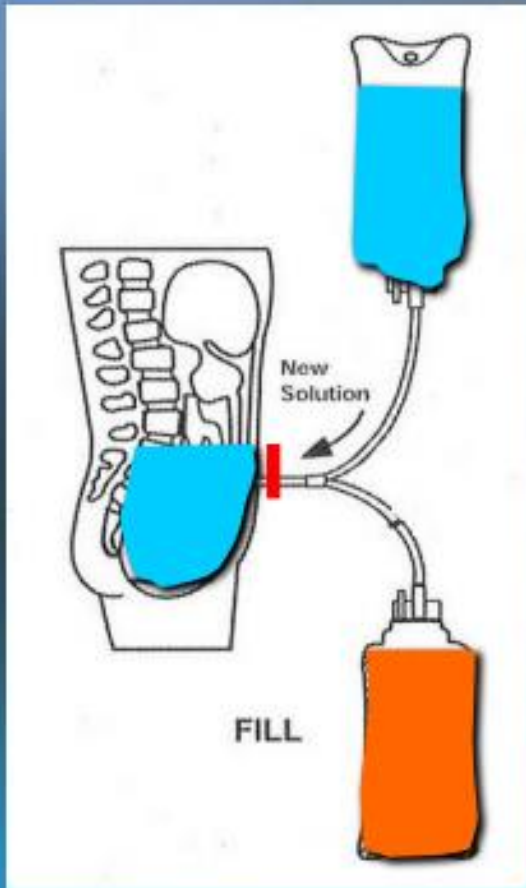


Controversia HDD VS DP

RAFAEL ALONSO VALENTE

Servicio de Nefrología. Hospital Clínico Universitario de Santiago de Compostela (CHUS)

DP es mucho mas simple que la HD



Simplificar una cosa es un tipo de sabiduría

Introducción 1

- Interés por la diálisis en domicilio en los últimos años impulsado por los beneficios que aporta y por la necesidad de contener los costos en el contexto de condiciones económicas mundiales inestables.
- Se considera la primera opción de terapia sustitutiva renal en pacientes con enfermedad renal crónica.
- Desde el punto de vista socioeconómico la diálisis domiciliaria reduce los costes de la diálisis.

Introducción 2

- La DP es la modalidad de diálisis domiciliaria más común (supervivencia similar a la “HD en centro” y posiblemente superior en pacientes jóvenes, no diabéticos, sin sobrepeso y en los primeros 2-3 años de TRS).
- Los estudios de cohortes publicados también indican una mejor supervivencia de la HDD comparada con la “HD en centro” independientemente del régimen utilizado.
- Pocos estudios comparan el curso clínico de la HDD y la DP y hasta recientemente ninguno evaluaba específicamente a los pacientes que iniciaban TRS con modalidad domiciliaria.

Role of peritoneal dialysis in the era of the resurgence of home hemodialysis

John BURKART

First published: 08 July 2008 | <https://doi.org/10.1111/j.1542-4758.2008.00297.x> | Cited by: 3

✉ J. Burkart, MD, Wake Forest University Baptist Medical Center, Medical Center Boulevard, Winston Salem, NC 27157, U.S.A.

E-mail: jburkart@wfubmc.edu

Abstract

In recent years, there has been a resurgence of home hemodialysis (HHD) therapies. Given the small percentage of prevalent patients in the United States currently on home dialysis, an appropriate question is: What is the role of peritoneal dialysis (PD) in this era? Data suggest that in centers that are promoting the growth of HHD, their PD programs also tend to be very active. Furthermore, our experience and other data suggest that one should not worry about cannibalizing PD in order to grow HHD. Most HHD patients come from in-center hemodialysis or those patients transitioning from PD to another therapy. In fact, data suggest that in order to promote the growth of HHD, a certain minimal infrastructure is needed in terms of staff. An active PD program not only supports a robust infrastructure that allows for HHD growth but also fosters profitability of a home program.

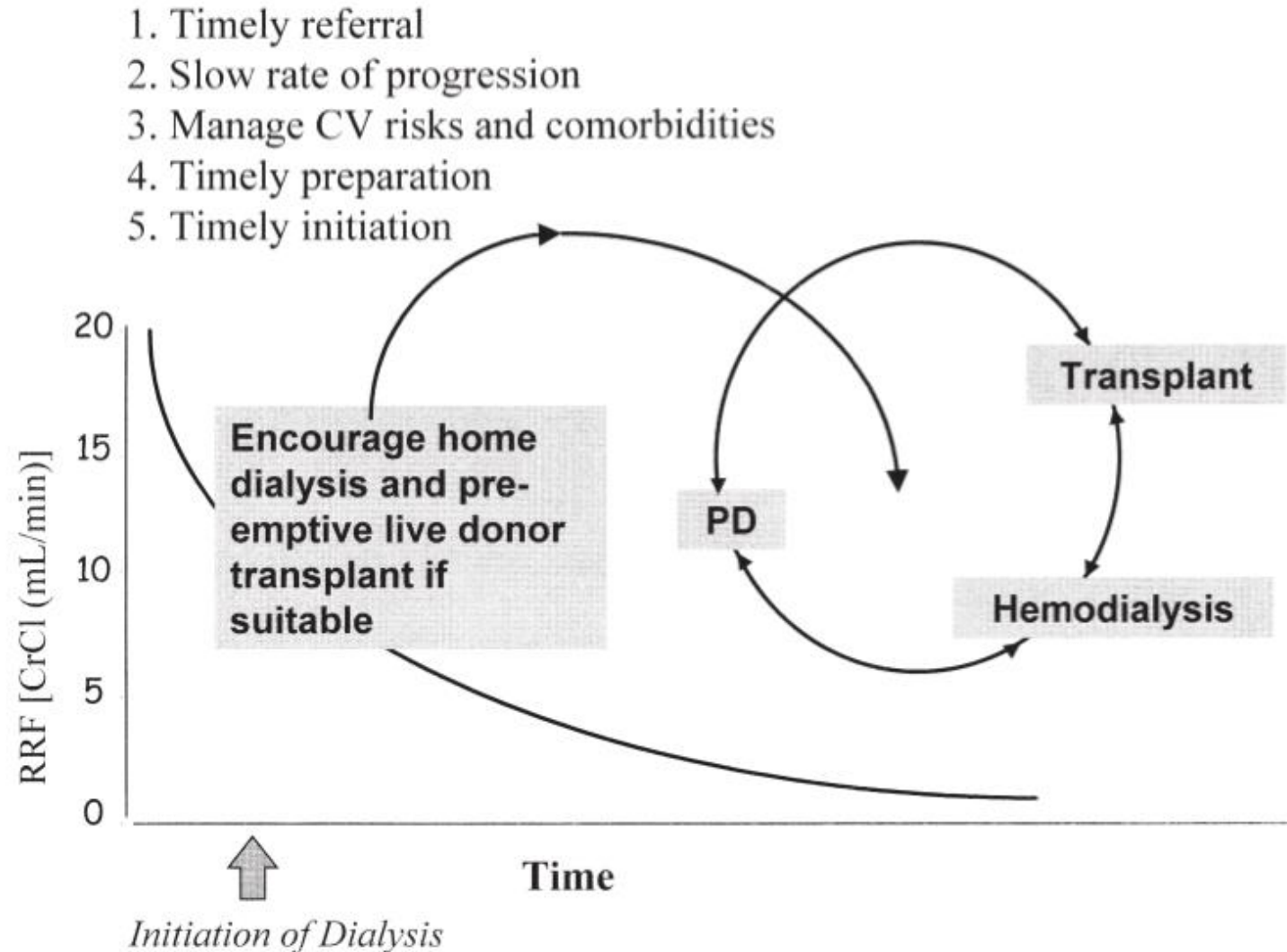


Volume 12, Issue s1
July 2008
Pages S51-S54

Ya en el 2008 decía.....

- En los últimos años, aumento de la terapias de hemodiálisis en domicilio (HDD).
- ¿Cuál es el papel de la DP en esta época?.
- En los centros que promueven el crecimiento de la HDD, sus programas de DP también tienden a ser muy activos.
 - **No debe preocuparnos el que pudiera sacrificarse la diálisis peritoneal para desarrollar HDD.** La mayoría de los pacientes con HDD provienen de hemodiálisis en centros hospitalarios o concertados o en transición de DP a otra terapia.
 - **Se necesita una cierta infraestructura mínima en términos de personal.** Un programa de DP activo no solo es compatible con una infraestructura sólida que permite el crecimiento de HDD, sino que también fomenta la rentabilidad de un programa domiciliario.

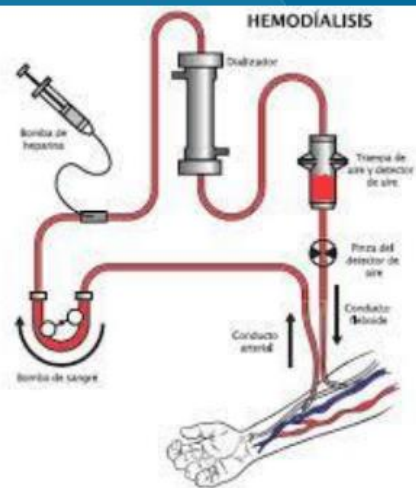
Concepto de Tratamiento Integral del Enfermo Renal Crónico



Preguntas a debate

¿Cuál es la mejor modalidad de diálisis domiciliar para pacientes incidentes?

¿Pueden ayudarnos los estudios epidemiológicos existentes a responder esta cuestión?

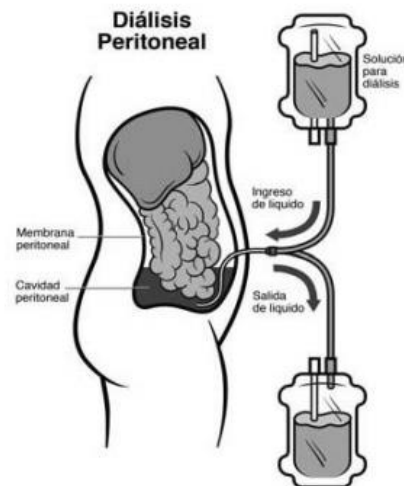


Tipos de acceso vascular:
Fístulas arterio-venosas
Catéteres venosos centrales

Extracción de la sangre

Filtración de la sangre en el dializador

Reentrada de la sangre filtrada al cuerpo



Conexión del catéter peritoneal y bolsa de diálisis

Desconexión del catéter

Intercambio de solutos en la membrana peritoneal

Apertura del sistema de infusión del líquido de diálisis

Apertura del catéter para drenar el líquido presente en la cavidad abdominal

Cierre del sistema de drenaje



Preliminary Communication

Systematic differences among patients initiated on home haemodialysis and peritoneal dialysis: the fallacy of potential competition

The systematic differences of home dialysis patients 2365

Jean-Philippe
Correspondence:

Table 1. Baseline characteristics of patients who initiated PD or HHD between 2004 and 2008

	PD patients (n = 153)	HHD patients (n = 83)	P-value
Gender (male), n (%)	87 (57)	58 (70)	0.05
Age at start of modality (years)	62 ± 16	46 ± 13	<0.001
Ethnicity			0.2
Caucasian	73 (48)	48 (58)	
Black	19 (12)	4 (5)	
Asian	34 (22)	17 (20)	
Other	27 (18)	14 (17)	
Aetiology of ESRD, n (%)			<0.001
Diabetic nephropathy	54 (35)	12 (14)	
Glomerulonephritis	24 (16)	26 (31)	
Polycystic kidney disease	7 (4)	9 (11)	
Hypertensive nephropathy	24 (16)	4 (5)	
Drug toxicity	9 (6)	3 (4)	
Other	35 (23)	29 (35)	
Comorbidities, n (%)			
Diabetes	69 (45)	20 (24)	0.003
Hypertension	140 (92)	70 (84)	0.09
Angina	20 (22)	8 (10)	0.03
Myocardial infarction	29 (19)	11 (13)	0.3
CABG	22 (14)	11 (13)	0.08
Cerebrovascular disease	26 (17)	6 (7)	0.04
Peripheral vascular disease	30 (20)	5 (6)	0.005
Malignancy	22 (14)	8 (10)	0.3
Patients followed up prior to RRT ^a , n (%)	131 (86)	54 (65)	<0.001
Intended treatment of the patient ^b , n (%)			<0.001
PD	45 (29)	2 (2)	
HD	2 (1)	21 (25)	
Undecided	106 (69)	60 (72)	

PD, peritoneal dialysis; HHD, home haemodialysis; ESRD, end-stage renal disease; CABG, coronary artery bypass graft; RRT, renal replacement therapy. Continuous variables were expressed as mean ± standard deviation and compared using the Mann–Whitney test. Categorical variables were expressed as percentage or number and compared using the Pearson’s chi-square test.

^aPatients with at least one outpatient visit with a nephrologist before the first dialysis.

Systematic differences among patients initiated on home haemodialysis and peritoneal dialysis: the fallacy of potential competition

Table 2. Process of care of patients initiating PD or HHD from 2004 to 2008

	PD patients (n = 153)	HHD patients (n = 83)	P-value
Origin of patient when RRT was initiated			<0.001
ARF from the emergency room			
ARF in an hospitalized patient			
Nephrology clinic (outpatient)			
Unknown			
Other RRT modality prior initiation			<0.001
First permanent renal replacement modality			<0.001
PD			
In-centre HD			
HHD			
Kidney transplant			
Self-care haemodialysis			
Access at time of first dialysis, n			<0.001
PD catheter			
Fistula			
Graft			
Permanent jugular catheter			
Temporary jugular catheter			
Unknown			
RRT vintage prior initiation of home dialysis			0.002
Mean $\pm$ SD (years)	0.34 $\pm$ 0.69	4.8 $\pm$ 6.8	
Median and interquartile range (years)	0.07 (0.03 – 0.3)	0.41 (0.0 – 9.4)	<0.001

PD, peritoneal dialysis; HHD, home haemodialysis; ARF, acute renal failure; HD, haemodialysis; RRT, renal replacement therapy; CAPD, continuous ambulatory peritoneal dialysis; APD, automated peritoneal dialysis. Continuous variables were expressed as mean $\pm$ standard deviation or median and range and compared using the Mann–Whitney test. Categorical variables were expressed as percentage or number and compared using the Pearson's chi-square test.

^aCircumstance of initiation of RRT.

^bDelay between the first renal replacement modality and the initiation of home dialysis (PD or HHD).

Diálisis Peritoneal vs HD Domiciliaria

**¿Que es lo que
nos interesa
comparar?**



MORTALIDAD?

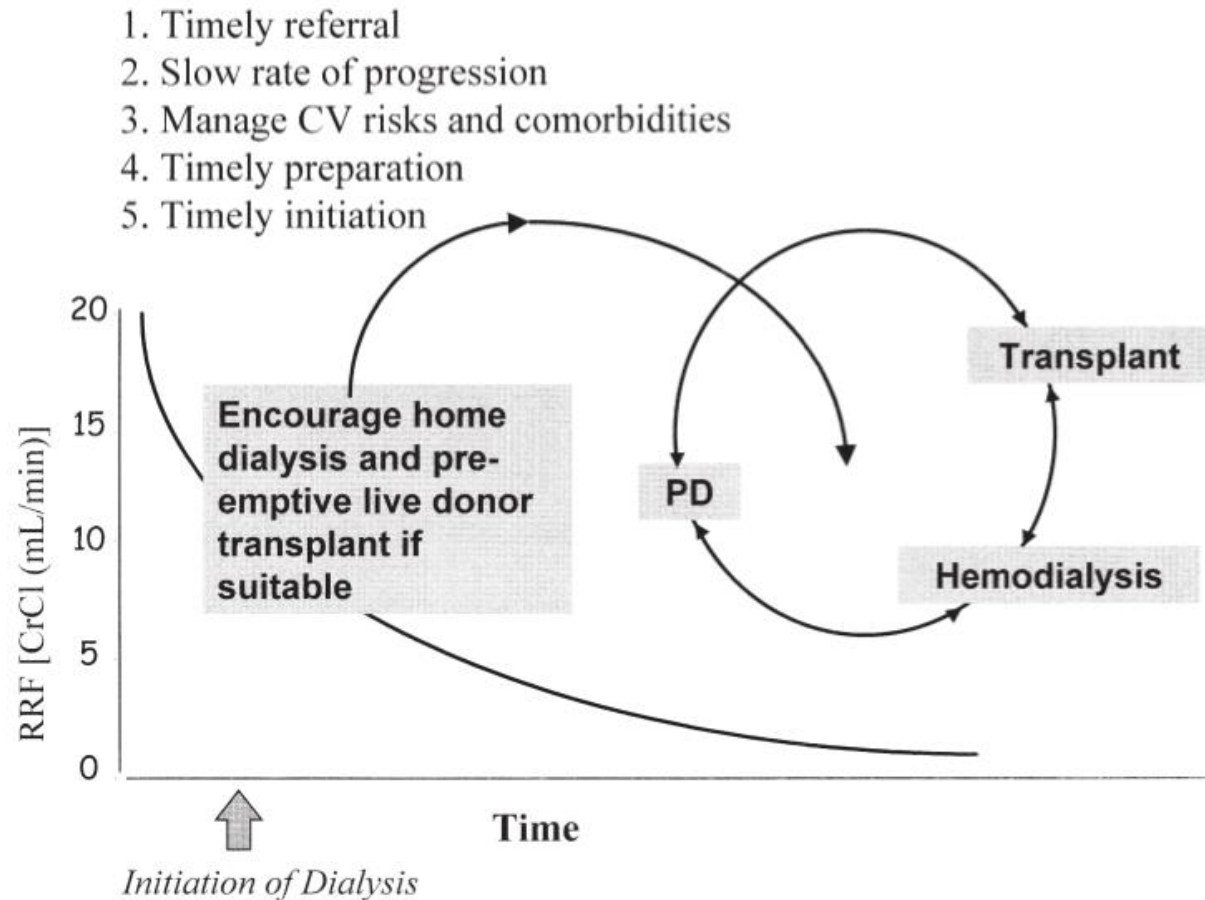
HOSPITALIZACIÓN?

FALLO DE LA TÉCNICA?

CALIDAD DE VIDA?

Objetivo

Mayor supervivencia GLOBAL en cada paciente



La supervivencia de cada técnica individualmente es menos relevante

Health technology assessment of the different dialysis modalities in Norway

Report from Kunnskapssenteret (Norwegian Knowledge Centre for the Health Services)
No 19–2013
Health technology assessment HTA

Health Technology Assessment of the Different Dialysis Modalities in Norway [Internet].

Pike E, Hamidi V, Ringerike T, Wisløff T, Desser A, Harboe I, Klemp M.

Oslo, Norway: Knowledge Centre for the Health Services at The Norwegian Institute of Public Health (NIPH); 2013 Dec. Report from Norwegian Knowledge Centre for the Health Services (NOKC) No. 19-2013.
[NIPH Systematic Reviews](#).

Excerpt

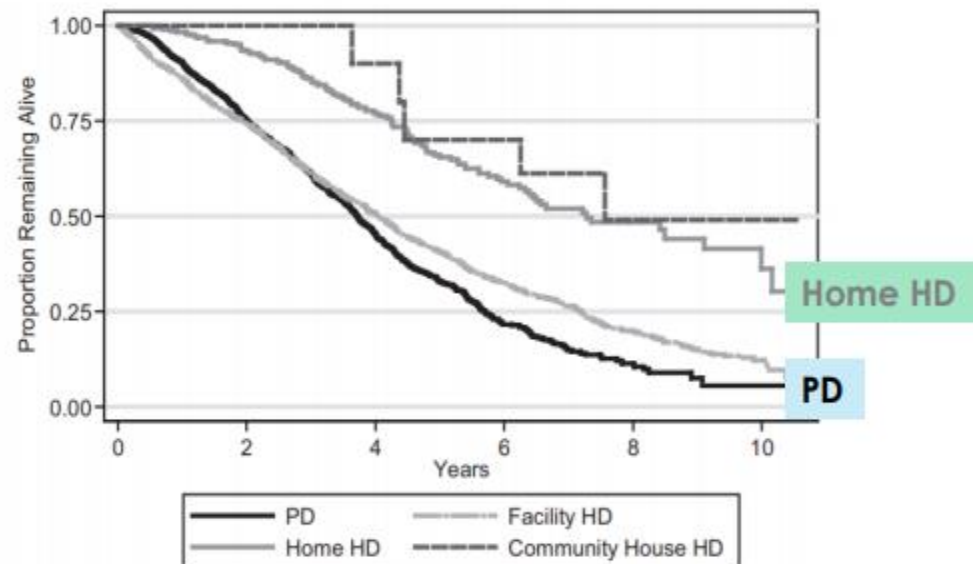
During the last ten years, the number of dialysis patients has doubled in Norway. After a request from The Norwegian Directorate of Health we performed a Health Technology Assessment comparing efficacy, safety and cost-effectiveness of the different dialysis modalities 1) Hemodialysis carried out in hospital, 2) self-care hemodialysis in hospital, 3) hemodialysis in satellite unit (nursing home, local medical centre), 4) hemodialysis at home and 5) peritoneal dialysis at home for patients with end-stage renal failure requiring dialysis in Norway. Our outcomes were mortality, complications that require special measures and quality of life. **Clinical findings** Of 21 possible comparisons only six had published data. For the comparisons with published data and low quality of the evidence, we found: no significant differences in mortality, in quality of life or in infections; significantly fewer hospitalisation days per patients per year in the hemodialysis hospital group versus the peritoneal dialysis at home group. **Economic evaluation:** In our model analyses all dialysis modalities were almost equally effective. Hemodialysis at home was the most effective and cost-effective alternative compared to all other hemodialysis modalities from both healthcare and societal perspectives. Peritoneal dialysis was the least costly, and hence the most cost-effective alternative compared to all hemodialysis modalities. The results of our sensitivity analysis showed that cost data had the greatest impact on the results' uncertainty.



Independent Community House Hemodialysis as a Novel Dialysis Setting: An Observational Cohort Study

Mark R. Marshall, BHB, MBChB, FRACP, MPH (Hons),^{1,2,3} Nora van der Schrieck,⁴
David Lilley, BEM,⁵ Sharen K. Supershad, MBBCh, FRACP,⁶
Alvin Ng, MBChB, FRACP,² Rachael C. Walker, NP, RN, BN, MN,⁷ and
Joanna L. Dunlop, MBBS, BSc, FRACP^{1,2}

- New Zealand 2000-2010
- 4709 pacientes analizados
- Objetivo primario
 - Mortalidad global





An Incident Cohort Study Comparing Survival on Home Hemodialysis and Peritoneal Dialysis (Australia and New Zealand Dialysis and Transplantation Registry)

- Australia and NZ, 2000-2012
- HHD (706 patients) versus PD patients (10,710 patients)
- Home dialysis < **90 days** after RRT start
- Primary outcome
 - Overall mortality

Table 1. Baseline characteristics

Characteristic	Peritoneal Dialysis (n=10,710)	Home Hemodialysis (n=706)
Age (yr)	62 (50, 71)	50 (42, 58)
Men	6082 (57)	531 (75)
Race		
White	7389 (69)	590 (84)
Asian	1236 (12)	47 (7)
Aboriginal/Torres Strait Islander	601 (6)	7 (1)
Maori	899 (8)	33 (5)
Pacific Peoples	468 (4)	24 (3)
Other	117 (1)	5 (1)
Primary kidney disease		
GN/autoimmune	2662 (25)	273 (39)
Diabetes	3739 (35)	126 (18)
Hypertension/renovascular	1526 (14)	47 (7)
Polycystic kidney disease	593 (6)	132 (19)
Reflux	338 (3)	39 (6)
Other/unknown	1852 (17)	89 (13)
Cigarette use (current)	1458 (14)	85 (12)
Comorbidities at dialysis entry		
Chronic lung disease	1606 (15)	54 (8)
Coronary disease	4060 (38)	122 (17)
Periphery vascular disease	2585 (24)	61 (9)
Cerebrovascular disease	1594 (15)	32 (5)
Diabetes	4648 (43)	159 (23)

Mortalidad global: incidentes en Hemodiálisis Domiciliaria/Diálisis Peritoneal

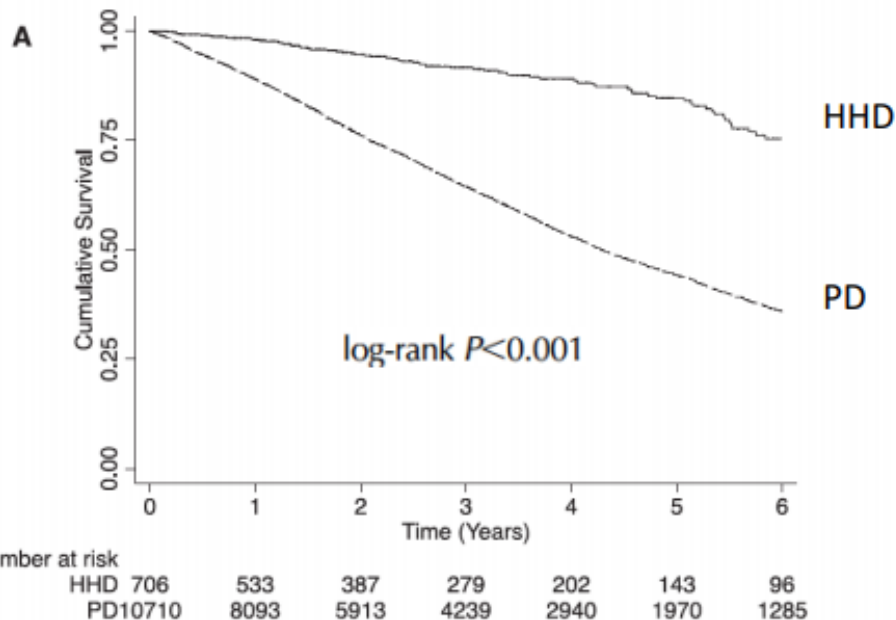


Table 2. Adjusted hazard ratios for mortality (primary outcome) comparing home hemodialysis with peritoneal dialysis

Models	HR	95% CI	P Value
Main model			
Multivariable adjustment ^a	0.47	0.38 to 0.59	<0.001
Secondary models			
PS quintile-stratified ^b	0.48	0.39 to 0.60	<0.001
PS-matching (robust) ^c	0.48	0.37 to 0.62	<0.001
Sensitivity model			
Competing risk ^d	0.42	0.34 to 0.52	<0.001

Datos demográficos (DP vs HDD)

Characteristic	Peritoneal Dialysis (n=10,710)	Home Hemodialysis (n=706)	P Value
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Cerebrovascular disease	1594 (15)	32 (5)	<0.001
Diabetes	4648 (43)	159 (23)	<0.001
Body mass index (kg/m ²)			<0.001
<20	823 (7)	32 (5)	
20–24.9	3451 (32)	177 (25)	
25–29.9	3712 (35)	248 (35)	
≥30	2682 (25)	243 (35)	
Late referral (<3 months)	2128 (20)	45 (6)	<0.001
eGFR	7.5 (5.6–9.9)	7.5 (5.8–9.4)	0.59

DP vs HDD: Mortalidad (incidentes)

➤ Limitaciones,

- No se analizaron ni cuantificaron las diferentes modalidades de HDD (frecuencias/número de horas por sesión).
- Los pacientes tratados con HDD son mas jóvenes y “sanos” que los pacientes tratados con DP.
- Poblaciones de estudio muy diferentes!!!.

***SUPERVIVENCIA A FAVOR DE HDD PODRIA ESTAR RELACIONADA
CON VARIABLES NO ANALIZADAS MAS QUE POR EL TRATAMIENTO
EN SI MISMO***

Mortality, Hospitalization, and Technique Failure in Daily Home Hemodialysis and Matched Peritoneal Dialysis Patients: A Matched Cohort Study

Eric D. Weinhandl, PhD,¹ David T. Gilbertson, PhD,¹ and Allan J. Collins, MD^{1,2}

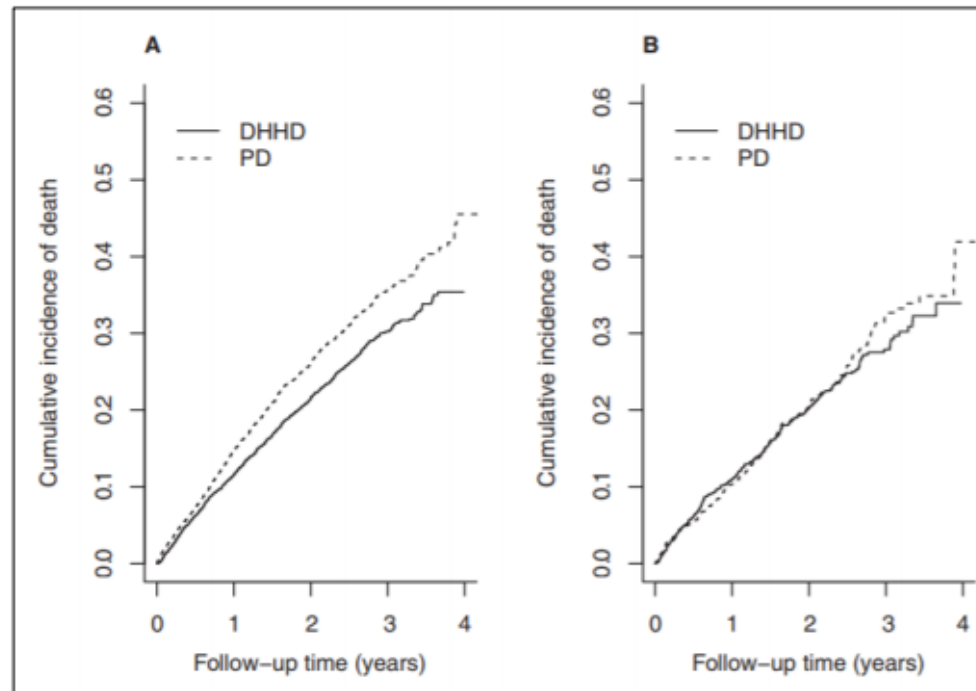
Background: Use of home dialysis is growing in the United States, but few direct comparisons of major clinical outcomes on daily home hemodialysis (HHD) versus peritoneal dialysis (PD) exist.

Study Design: Matched cohort study.

Setting & Participants: We matched 4,201 new HHD patients in 2007 to 2010 with 4,201 new PD patients from the US Renal Data System database.

Predictor: Daily HHD versus PD.

Outcomes: Relative mortality, hospitalization, and technique failure.



When all patients analyzed, mortality was lower with daily HHD vs. PD (HR 0.8)

When a subset of patients with ESRD duration < 6 months was analyzed, the survival difference disappeared

Mortality, Hospitalization, and Technique Failure in Daily Home Hemodialysis and Matched Peritoneal Dialysis Patients: A Matched Cohort Study

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Predictor: Daily HHD versus PD.

Outcomes: Relative mortality, hospitalization, and technique failure.

➤ LIMITACIONES

- Factores no medidos que pueden influir como la FRR.
- Falta de datos con respecto a la frecuencia, duración y dosis de diálisis en pacientes con HHD diaria y frecuencia y tipo solución en pacientes en DP
- Poblaciones de estudio muy diferentes!!!!.



Original Investigation

Mortality and Hospitalizations in Intensive Dialysis: A Systematic Review and Meta-Analysis

Anna Mathew¹, Jody-Ann McLeggon², Nirav Mehta²,
Samuel Leung², Valerie Barta², Thomas McGinn²,
and Gihad Nesrallah^{3,4}

Canadian Journal of Kidney Health
and Disease
Volume 5: 1–18
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DOI: 10.1177/2054358117749531
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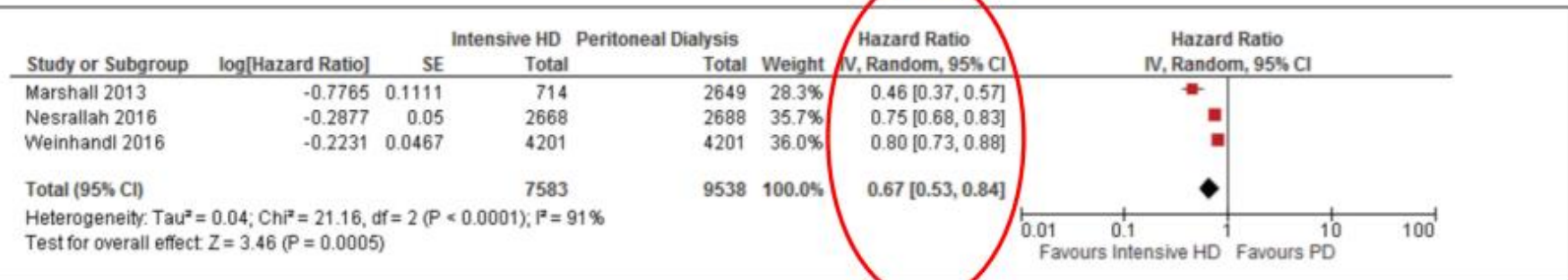


Figure 5. Comparative risk of mortality in intensive HD versus PD.



Original Investigation

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Samuel Leung², Valerie Barta², Thomas McGinn²,
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Canadian Journal of Kidney Health
and Disease
Volume 5: 1–18
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DOI: 10.1177/2054358117749531
journals.sagepub.com/home/cjk
 SAGE

Table 8. GRADE Evidence Profile Table: Effects of Intensive HD Compared With PD in Patients on Chronic HD.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intensive HD	PD	Relative (95% CI)	Absolute (95% CI)		
Mortality												
3	Observational studies	Serious ^a	Serious ^b	Not serious	Not serious	None	-/7583	-/9538	HR 0.67 (0.53 to 0.84)	— ^c	⊕○○○ Very low	Critical

Note. HD = hemodialysis; PD = peritoneal dialysis; CI = confidence interval; HR = hazard ratio.

^aConcern for lack of matching on prognostic factors and adjustment in statistical analysis.

^b $I^2 = 91\%$ for pooled effect estimate, with unexplained heterogeneity possibly due to study design and population.

^cAbsolute event counts not provided, precluding estimation of absolute event rates.

Diálisis Peritoneal vs HD Domiciliaria

**¿Que es lo que
nos interesa
comparar?**



MORTALIDAD?

HOSPITALIZACIÓN?

FALLO DE LA TÉCNICA?

CALIDAD DE VIDA?

Mortality, Hospitalization, and Technique Failure in Daily Home Hemodialysis and Matched Peritoneal Dialysis Patients: A Matched Cohort Study

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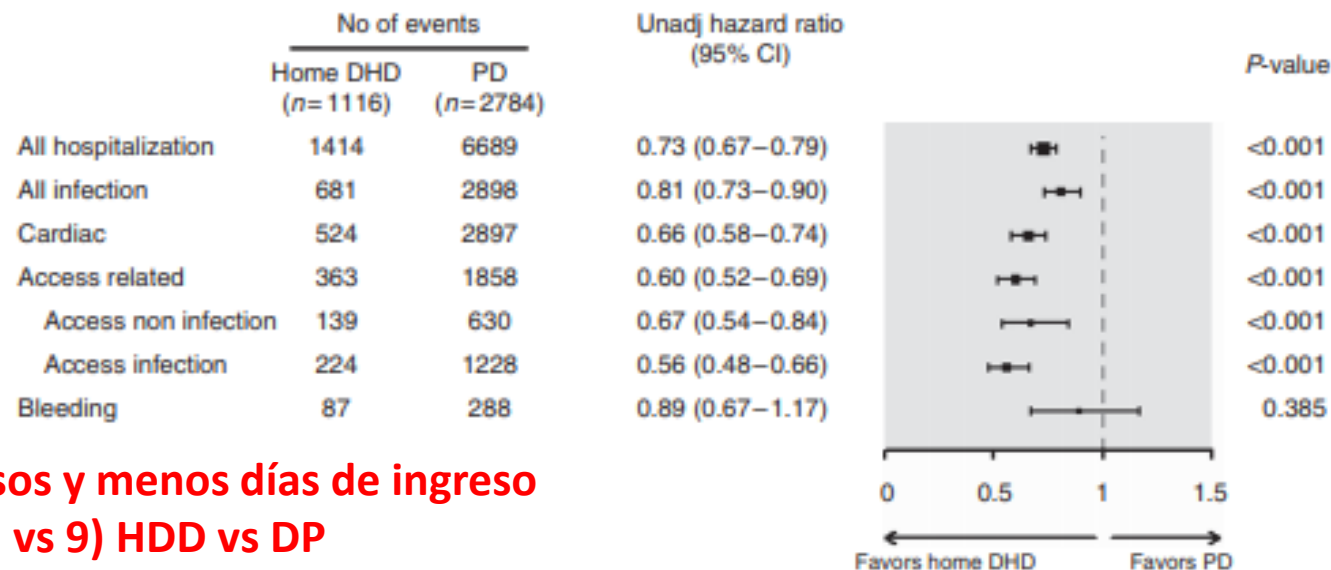
Outcomes: Relative mortality, hospitalization, and technique failure.

- Riesgo de hospitalización 8% menor para todas las causas con HDD frente a DP.
- Menos días de ingreso con HHD vs. DP (RR 0,81).
- Menor índice de hospitalización por ECV con HDD (RR 0,85).
- Menor índice de hospitalización por infección con HDD (RR 0,89), pero más bacteriemia /sepsis con HDD (RR 1.18).
- Sin embargo, entre aquellos paciente con < 6 meses de TRS, esta diferencia en la hospitalización entre las modalidades desapareció.

The risk of hospitalization and modality failure with home dialysis

Rita S. Suri^{1,2}, Lihua Li² and Gihad E. Nesrallah^{3,4}

¹Department of Medicine, Section of Nephrology, Centre de Recherche, Centre Hospitalier de l'Université de Montréal (CHUM), Montréal, Québec, Canada; ²Division of Nephrology, Western University, London, Ontario, Canada; ³Department of Nephrology, Humber River Regional Hospital, Toronto, Ontario, Canada and ⁴The Li Ka Shing Knowledge Institute, Keenan Research Centre, St. Michael's Hospital, Toronto, Ontario, Canada



**Menos ingresos y menos días de ingreso
(5 vs 9) HDD vs DP**

Figure 2 | Relative hazard of hospitalization associated with home daily home hemodialysis (DHD) versus peritoneal dialysis (PD).
CI, confidence interval; No, number.

Diálisis Peritoneal vs HD Domiciliaria

**¿Que es lo que
nos interesa
comparar?**

MORTALIDAD?

HOSPITALIZACIÓN?

FALLO DE LA TÉCNICA?

CALIDAD DE VIDA?

Mortality, Hospitalization, and Technique Failure in Daily Home Hemodialysis and Matched Peritoneal Dialysis Patients: A Matched Cohort Study

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Predictor: Daily HHD versus PD.

Outcomes: Relative mortality, hospitalization, and technique failure.

✓ Riesgo 37% mas bajo con HDD. (USRDS)

An Incident Cohort Study Comparing Survival on Home Hemodialysis and Peritoneal Dialysis (Australia and New Zealand Dialysis and Transplantation Registry)

Annie-Claire Nadeau-Fredette,^{*†‡} Carmel M. Hawley,^{*§} Elaine M. Pascoe,^{||} Christopher T. Chan,[¶] Philip A. Clayton,^{†**} Kevan R. Polkinghorne,^{*††‡§§||} Neil Boudville,^{*¶} Martine Leblanc,[‡] and David W. Johnson^{*†§}

✓ Riesgo 66% mas bajo con HDD. (ANZDATA)

The risk of hospitalization and modality failure with home dialysis

Rita S. Suri^{1,2}, Lihua Li² and Gihad E. Nesrallah^{3,4}

¹Department of Medicine, Section of Nephrology, Centre de Recherche, Centre Hospitalier de l'Université de Montréal (CHUM), Montréal, Québec, Canada; ²Division of Nephrology, Western University, London, Ontario, Canada; ³Department of Nephrology, Humber River Regional Hospital, Toronto, Ontario, Canada and ⁴The Li Ka Shing Knowledge Institute, Keenan Research Centre, St. Michael's Hospital, Toronto, Ontario, Canada

✓ Probabilidad 3.4 mayor con DP vs HDD. (CANADA)

Weinhandl et al, AJKD 2016
Nadeau-Fredette, CJASN 2015
Suri et al, KI 2015

Diálisis Peritoneal vs HD Domiciliaria

**¿Que es lo que
nos interesa
comparar?**

MORTALIDAD?

HOSPITALIZACIÓN?

FALLO DE LA TÉCNICA?

CALIDAD DE VIDA?

Cross-Sectional Comparison of Quality of Life and Illness Intrusiveness in Patients Who Are Treated with Nocturnal Home Hemodialysis *versus* Peritoneal Dialysis

Edwin Fong, Joanne M. Bargman, and Christopher T. Chan

Toronto General Hospital–University Health Network, Toronto, Ontario, Canada

➤ Un único centro, estudio transversal

- Tendencia hacia una mejor función sexual en el grupo HDD nocturno.
- Menor apoyo social en pacientes con HDD nocturna.
- No hay diferencia con respecto al índice de depresión de Beck.
- No hay diferencia en relación con la sensación de enfermedad percibida por el paciente.

¿Qué limita la calidad de vida de nuestros pacientes?

- Alta carga de síntomas.
- Problemas clínicos no resueltos.
- Necesidades no satisfechas.

¿Supervivencia o calidad de vida?

Survival by Dialysis Modality—Who Cares?

Martin B. Lee and Joanne M. Bargman†*

“En la práctica clínica, la elección de modalidad de diálisis debe ser individualizada con el objetivo de maximizar la calidad de vida, las expectativas esperadas por el paciente y lograr de esta manera los objetivos centrados en el paciente. Los pacientes se preocupan más por cómo vivirán en lugar de por cuánto tiempo”.

“It is our responsibility to align our research with their needs”

TRANSITIONS FROM PD ARE EXPECTED. WHY NOT CONTINUE AT HOME?

John Burkart

Perit Dial Int November-December 2007
27:645-646

➤ **Continuar con terapia domiciliaria puede mejorar la calidad de vida del paciente.**

Combined therapy using peritoneal dialysis and hemodialysis may increase the indications for peritoneal dialysis in the United States

[Nanae Matsuo](#), [Keitaro Yokoyama](#) , [Yudo Tanno](#), [Izumi Yamamoto](#), [Takashi Yokoo](#)

Kidney Int. 2015 Jun;87(6):1259-60.

An Evaluation of an Integrative Care Approach for End-Stage Renal Disease Patients

WIM VAN BIESEN, RAYMOND C. VANHOLDER, NIC VEYS,
ANNEMIEKE DHONDT, and NORBERT H. LAMEIRE
Renal Division, Department of Internal Medicine, University Hospital Gent, Belgium.

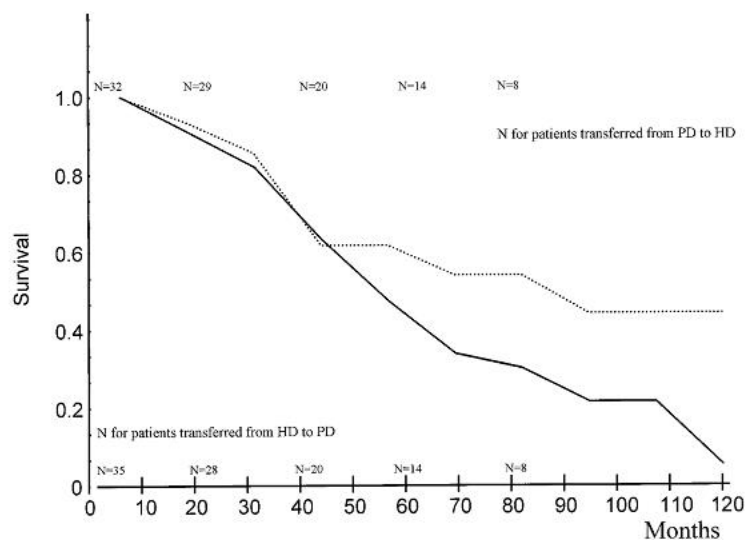


Figure 3. Log-rank analysis of patient intention-to-treat survival. Solid line, patients started on HD (without transfer); dotted line, patients started on PD and transferred afterward to HD. $P = 0.01$. N = event numbers.

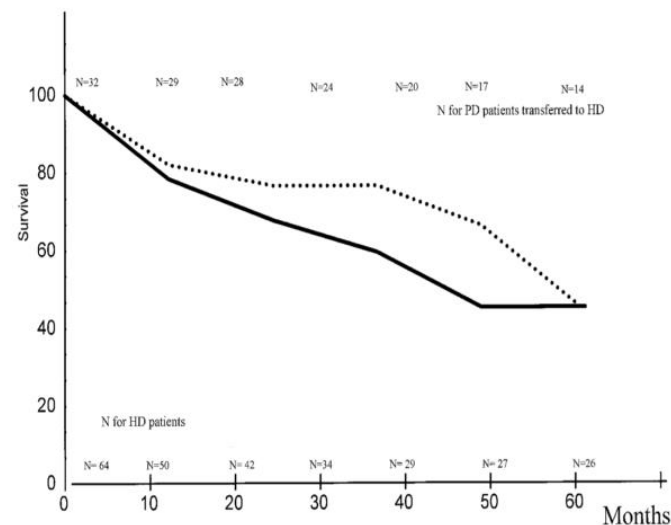


Figure 6. Log-rank survival analysis of matched pairs of integrative care patients and HD patients. Every integrative care patient was matched with two HD patients surviving at least as long on HD as the integrative care patient on PD. Survival is calculated from the moment of transfer of the integrative care patient from PD to HD. Dotted line, patients started on PD and transferred to HD; solid line, patients started and maintained on HD; N = event numbers.

Los pacientes que inician DP y se transfieren a HD tienen mejor supervivencia que los que inician y se mantienen en HD.

Preguntas sin respuesta

- 1.- Todos estos estudios y resultados, ¿son extrapolables a nuestros pacientes y en nuestro medio?.
- 2.- En la práctica clínica, ¿Cómo podemos aplicar estos resultados a un paciente candidato a diálisis peritoneal o a hemodiálisis domiciliaria?.
- 3.- ¿Qué es mejor diálisis peritoneal primero seguido de hemodiálisis domiciliaria o mejor hemodiálisis domiciliaria como primera opción?.
- 4.- ¿Qué pasaría si consideramos ambas técnicas domiciliarias como complementarias y no en competencia?.

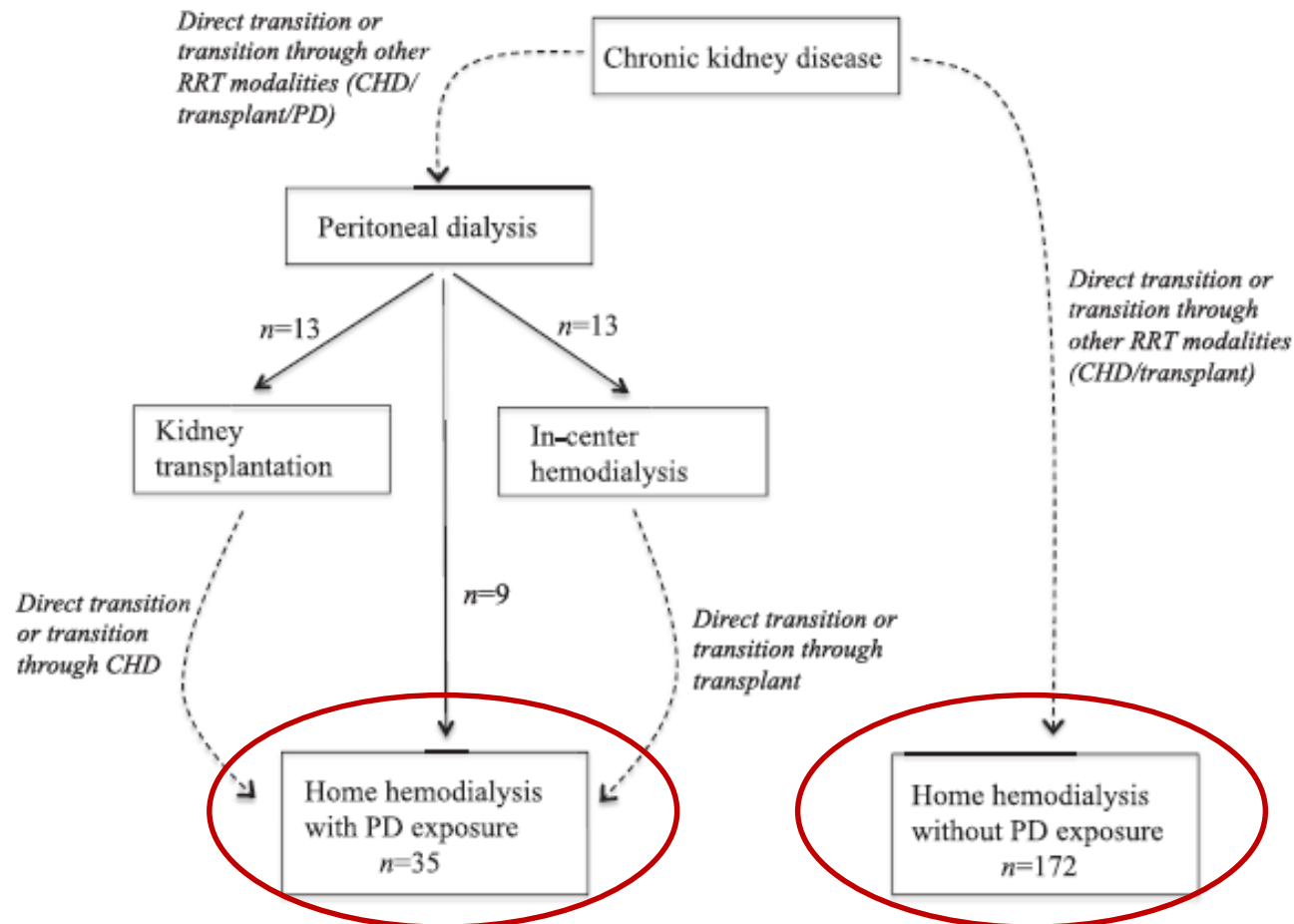
Modelo Integrado de Diálisis Domiciliaria

- Inicio de tratamiento sustitutivo de la función renal con diálisis peritoneal seguido hemodiálisis domiciliaria -----> **“DIALISIS ÓPTIMA”**: se magnifican las ventajas de ambas modalidades.

CLINICAL OUTCOME OF HOME HEMODIALYSIS IN PATIENTS WITH PREVIOUS PERITONEAL DIALYSIS EXPOSURE: EVALUATION OF THE INTEGRATED HOME DIALYSIS MODEL

Annie-Claire Nadeau-Fredette, Joanne M. Bargman, and Christopher T. Chan

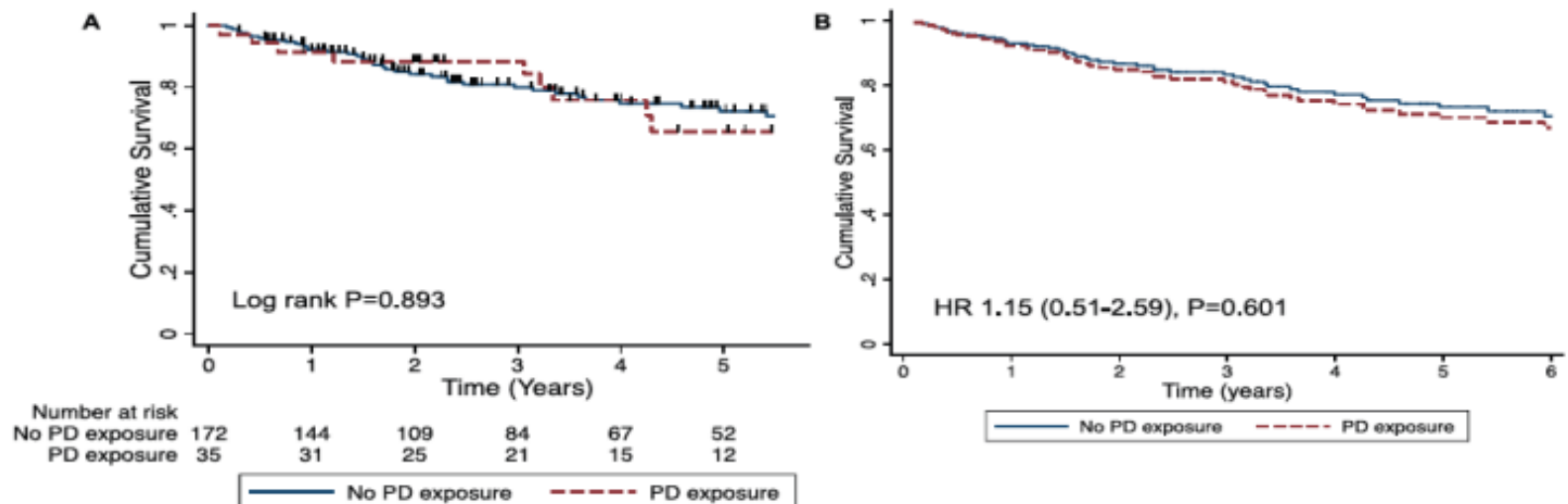
Toronto General Hospital – University Health Network, University of Toronto, Toronto, Ontario, Canada



CLINICAL OUTCOME OF HOME HEMODIALYSIS IN PATIENTS WITH PREVIOUS PERITONEAL DIALYSIS EXPOSURE: EVALUATION OF THE INTEGRATED HOME DIALYSIS MODEL

- All incident HHD patients – UHN Toronto, 1996-2011
- PD exposure before HHD (n=35) or none (n=172)

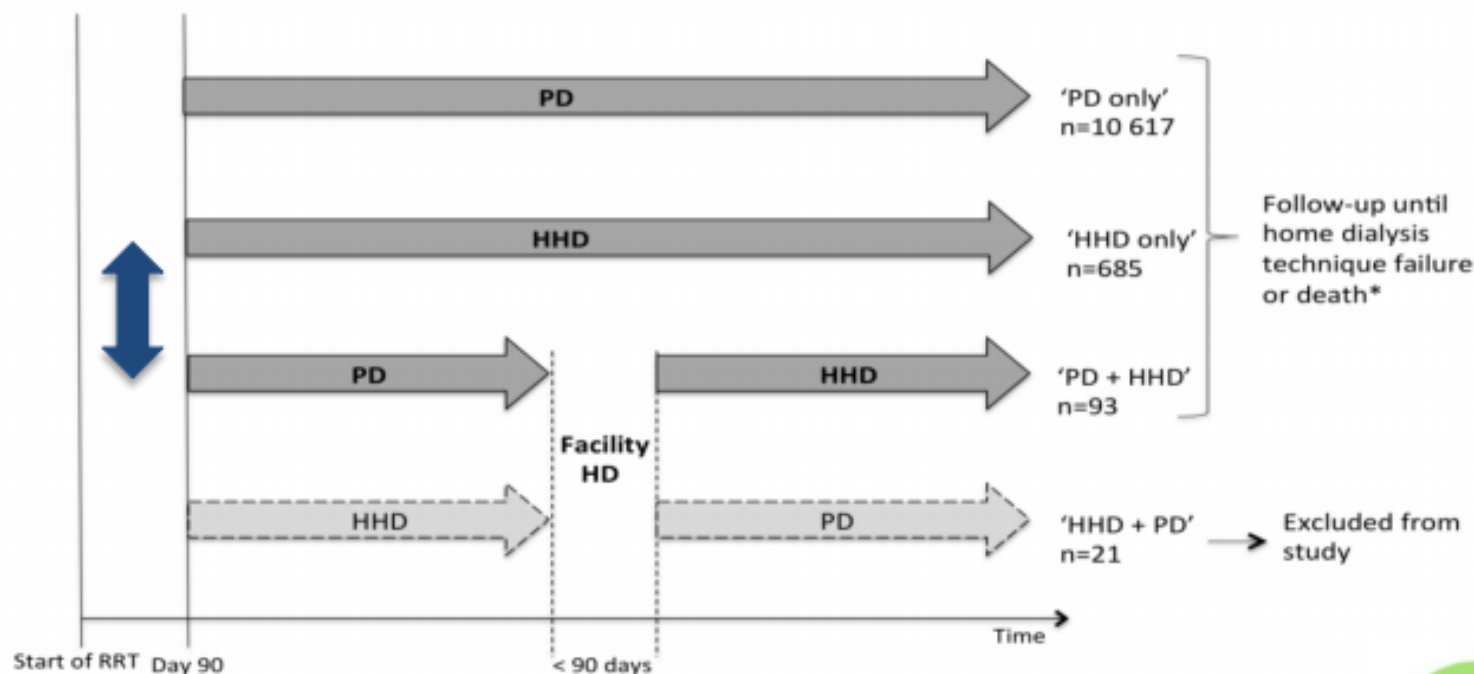
Patient and technique survival during HHD was similar for patients with and without previous PD exposure



✓ Patients with prior PD exposure had longer dialysis vintage (12.3 vs. 0.9 years) and higher Charleston comorbidity index

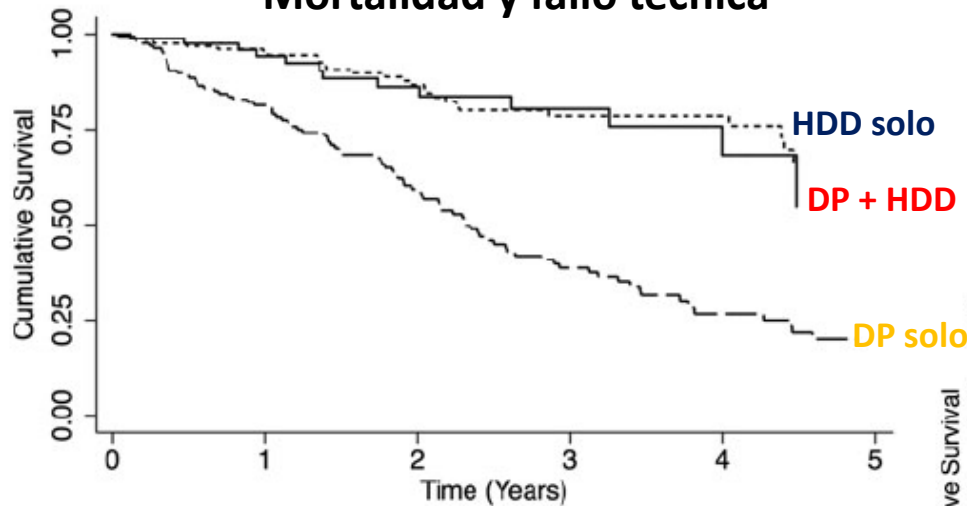
Outcomes of integrated home dialysis care: a multi-centre, multi-national registry study

¿Debe el paciente iniciar DP y finalizada esta cambiar a HDD o iniciar directamente en HDD?



Outcomes of integrated home dialysis care: a multi-centre, multi-national registry study

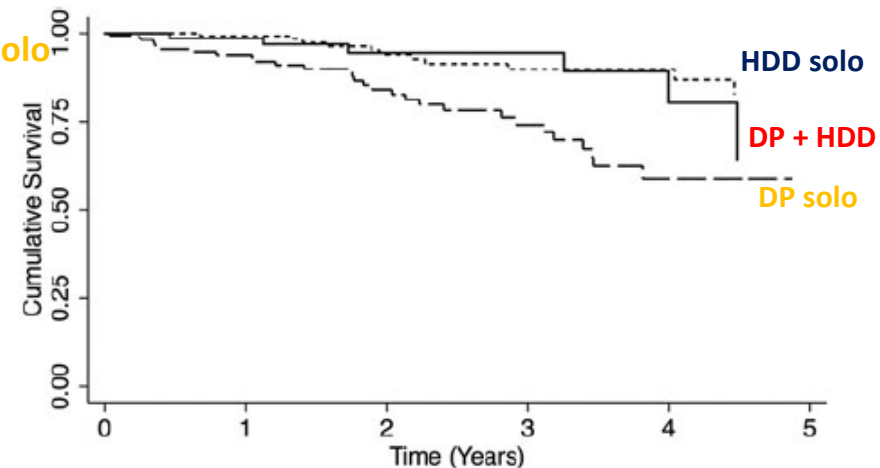
Mortalidad y fallo técnico



HDD, HR: 0.92, 95% CI: 0.52-1.62

PD, HR: 3.22, 95% CI: 1.97-5.25

Mortalidad



HDD, HR: 0.77, 95% CI: 0.34-1.72

DP, HR: 2.44, 95% CI: 1.19-4.98

Striving to Achieve an Integrated Home Dialysis System

A Report from the Ontario Renal Network Home Dialysis Attrition Task Force

Brendan B. McCormick and Christopher T. Chan for the ORN Home Dialysis Research Group

Clin J Am Soc Nephrol 13: 468–470, 2018. doi: <https://doi.org/10.2215/CJN.06900617>

- ✓ Promover el uso de diálisis en domicilio siendo la mejor estrategia iniciar con diálisis peritoneal y transferencia programada a HD domiciliaria sobre todo en pacientes con dificultades para trasplante.
- ✓ Concienciar sobre el modelo de transición de diálisis en casa (DP → HD domiciliaria).
- ✓ Establecer incentivos para favorecerla.
- ✓ Modelos de financiación que garanticen una compensación adecuada.
- ✓ Realizar análisis cualitativos y estudios clínicos que evalúen los resultados.

Conclusiones

- ✓ Mejor supervivencia del paciente y la técnica y menos hospitalizaciones con HDD en comparación con la DP (estudios observacionales).
- ✓ Sin embargo, las poblaciones estudiadas son intrínsecamente diferentes, lo que da lugar a confusión y sesgos importantes.
- ✓ En el modelo integrado de diálisis domiciliaria los pacientes incidentes en diálisis peritoneal y transferidos exitosamente a hemodiálisis domiciliaria en el momento de finalizar diálisis peritoneal tienen una mortalidad similar a la de los incidentes en hemodiálisis domiciliaria.
- ✓ Los motivos para la transición de diálisis peritoneal a hemodiálisis (en general) son múltiples y, con mayor frecuencia, están relacionados con factores no directamente relacionados con la técnica.
- ✓ La Diálisis Peritoneal se plantea como la primera opción de tratamiento en el modelo integrado de diálisis domiciliaria.

Conclusiones

- ✓ A la vista de todo, la elección de la modalidad de diálisis se debe basar en un proceso que incluye una educación global de las diferentes opciones teniendo en cuenta el modelo integral y considerando los costes para una toma de decisiones compartidas entre personal sanitario y pacientes.
- ✓ La preferencia del paciente y la calidad de vida deben estar a la vanguardia en la toma de estas decisiones.
- ✓ Concienciar sobre el modelo de transición de diálisis domiciliaria y orientar sobre su implementación deberían ser los objetivos del grupo de expertos a nivel mundial para favorecer el uso de esta estrategia de diálisis infrautilizada hasta la fecha.

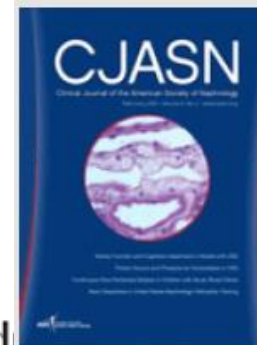
Peritoneal Dialysis First: Rationale

Kunal Chaudhary,^{*,†} Harbaksh Sangha,[†] and Ramesh Khanna[†]

Summary

The use of peritoneal dialysis (PD) has become wide spread since the introduction of PD more than 25 years ago. Over this time, many advances have been made and PD is an alternative to hemodialysis (HD), with excellent comparable survival, lower cost, and improved quality of life. The percentage of prevalent PD patients in the United States is approximately 7%, which is significantly lower compared with the 15% PD prevalence from the mid-1980s. Despite comparable survival of HD and PD and improved PD technique survival over the last few years, the percentage of patients performing PD in the United States has declined. The increased numbers of in-center HD units, physician comfort with the modality, perceived superiority of HD, and reimbursement incentives have all contributed to the underutilization of PD. In addition to a higher transplantation rate among patients treated with PD in the United States, an important reason for the low PD prevalence is the transfer to HD. There are various reasons for the transfer (e.g., episodes of peritonitis, membrane failure, patient fatigue, etc.). This review discusses the various factors that contribute to PD underutilization and the rationale and strategies to implement “PD first” and how to maintain it. The PD first concept implies that when feasible, PD should be offered as the first dialysis modality. This concept of PD first and HD second must not be seen as a competition between therapies, but rather that they are complementary, keeping in mind the long-term goals for the patient.

Clin J Am Soc Nephrol 6: 447–456, 2011. doi: 10.2215/CJN.07920910



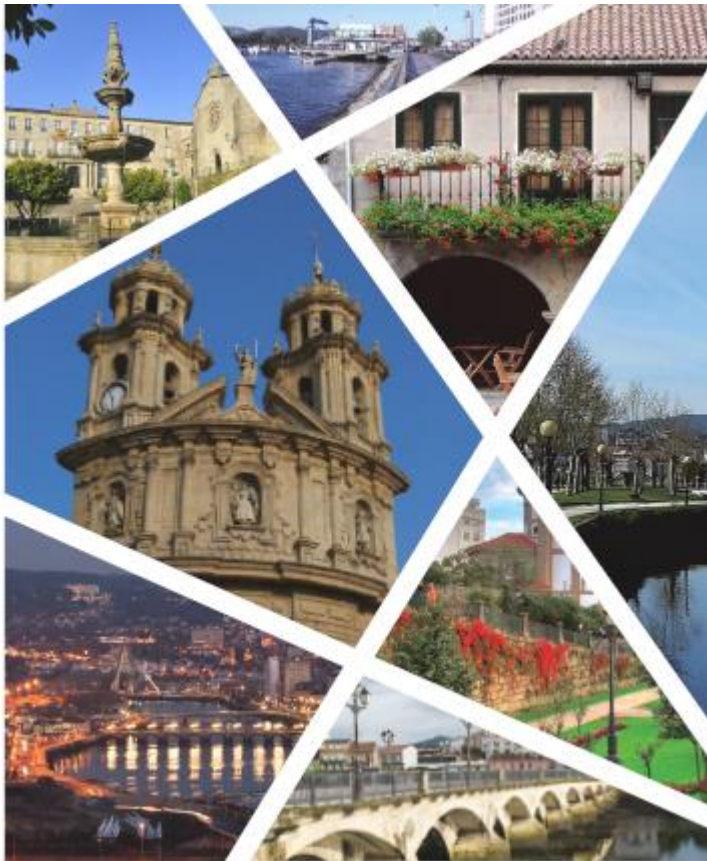
Revista clínica de la Sociedad
Americana de Nefrología
Vol. 6 , Número 2
1 de febrero de 2011
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**COMPLEMENTARIEDAD CON OBJETO DE OBTENER A LARGO PLAZO
LOS MEJORES RESULTADOS PARA EL PACIENTE**

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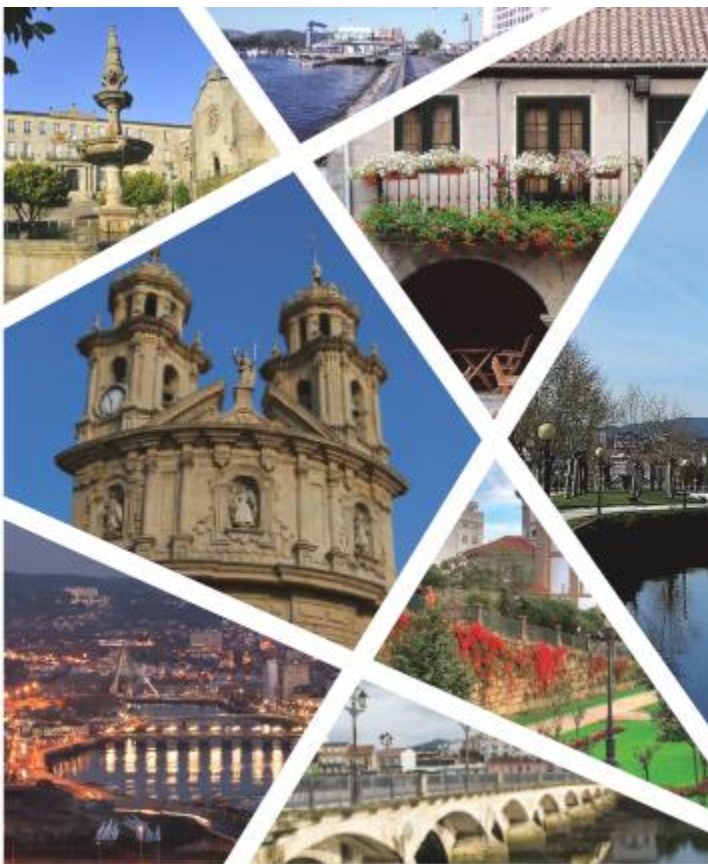
***Controversia
HDD VS DP***

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Modelo integrado de Diálisis Domiciliaria: DP con HDD



Muchas gracias