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Focus on home dialysis at Home Therapies 2010 Workshop

The third Australian and New Zealand workshop on home dialysis was held in early February in Brisbane. The first such workshop was held in Christchurch in July 2004. For the first time the workshop addressed both peritoneal and haemodialysis at home. The workshop was well attended with four international and 24 Australian and New Zealand speakers. The attendance was the best ever with 290 registrants.

Australia and New Zealand are world leaders in the provision of home dialysis and New Zealand is number three in the world for peritoneal dialysis with 36% of all dialysis patients on this therapy. A number of studies have shown that home haemodialysis and peritoneal dialysis have been shown to be cheaper than other forms of dialysis and to have the best outcomes in a number of studies.

Professor Alan Cass from the George Institute in Sydney discussed the economics of home dialysis in Australia. He estimated that the treatment of CKD, including dialysis and transplantation, cost at least 1 billion dollars in Australia. The Federal and State governments cover only about 70% of health funding with 15% of health spending "out of pockets" costs borne by the patient. Other speakers provided evidence of these costs for dialysis patients and estimated that for those on home dialysis there was an annual "out of pocket" cost of AUS \$2,000.

Polls of nephrologists consistently report that if they needed dialysis they would prefer home haemodialysis with a fistula and long hours (usually overnight). In a recent Australian study 95 dialysis and transplant patients were interviewed to find out what they thought of the different types of treatment for kidney failure. Patients valued treatments that enhanced their freedom and autonomy and were convenient, effective, and simple. Treatments that minimized confinement and risk also were viewed positively. Interestingly the likely survival on a particular treatment did not appear to be important when making a choice. The authors suggested that patients might choose between therapies based on their perception regarding which therapy most embodies particular characteristics that minimize impact on their lifestyle and that these factors should be taken into account when providing patients with information on treatment choices.

Dr John Agar, a champion of nocturnal dialysis from Geelong, told the workshop the rates of home dialysis varied greatly across Australia. Rates for home haemodialysis in units with more than 100 patients ranged from one to 15 percent and for peritoneal dialysis from 19 to 30 percent. These compare with New Zealand rates of less than five to 40 percent for home haemodialysis and 22 to 49 percent for peritoneal dialysis. Dr Agar concluded that these differences were likely due to “local unit medical and/or nursing mindsets” and the type of pre-dialysis education offered. He could find no medical evidence for these differences.

Dr Mark Marshall from Middlemore Hospital gave an elegant presentation of his work looking at survival on the various forms of haemodialysis. He found that people on home haemodialysis lived longer than those on satellite or hospital (centre) dialysis even taking into account differences in the general health of these three groups of patients. His studies suggest that having dialysis at home, rather than in hospital or a satellite unit, is the most important factor for this improved survival.

In the early days, most home dialysis patients carried out their treatments overnight for 8-10 hours three times a week and reported a good quality of life. Many New Zealand home dialysis patients still do overnight dialysis. There has been renewed interest in the benefits of this type of long hours dialysis in parts of the world where the lessons of the past have been forgotten. A recent study of survival for patients on nocturnal dialysis (6–8 h on 3–7 nights per week) in North America showed that remarkably these patients had a survival the same as patients receiving a deceased donor transplant.

While we can take satisfaction from the evidence that patients in Australia and New Zealand have reasonable access to both forms of home dialysis the rates of peritonitis for those on peritoneal dialysis give cause for concern. Peritoneal dialysis patients in New Zealand, particularly Maori, have a much higher chance of getting peritonitis than in other countries. The causes for these differences are not clear and require further research.

This workshop confirmed to me that home dialysis is clearly the best form of dialysis and we must strive in New Zealand to ensure that all people with kidney failure have access to this treatment.

More information on this conference can be found at
<http://www.hometherapiesworkshop.com.au/>

Chronic kidney disease is common, harmful and treatable.

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