

Dialysebeginn im internationalen Vergleich: Zu oft ?

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 **KfH** Kuratorium für Dialyse und
Nierentransplantation e.V.
Gemeinnützige Körperschaft

„Zu oft ?“ - Definition

- ✓ Sterblichkeitsrisiko > Dialysegewinn
 - verkürzte Lebenserwartung
 - verschlechterte Lebensqualität
 - Mißverhältnis von Ressourceneinsatz zu QALY
- Dialyse aus „ökonomischen Interesse“*

*) Keller F et al. Med. Klinik, 2007

Faller et al. *BMC Nephrology* 2013, **14**:103
<http://www.biomedcentral.com/1471-2369/14/103>



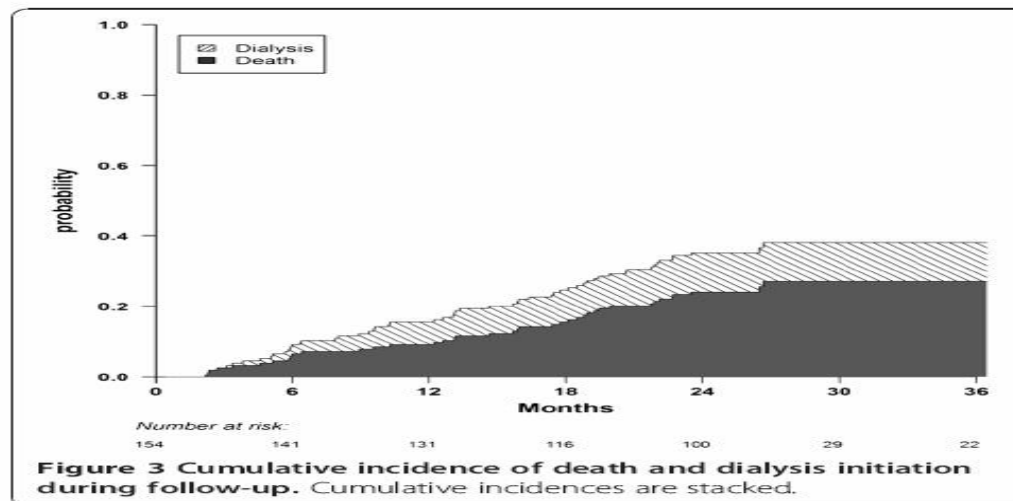
RESEARCH ARTICLE

Open Access

Competing-risk analysis of death and dialysis initiation among elderly (≥ 80 years) newly referred to nephrologists: a French prospective study

Bernadette Faller¹, Jean-Baptiste Beuscart², Luc Frimat^{3,4*} and on behalf of the 'Association des néphrologues de l'Est'

Konkurrierendes Risiko von Tod und Dialysebeginn

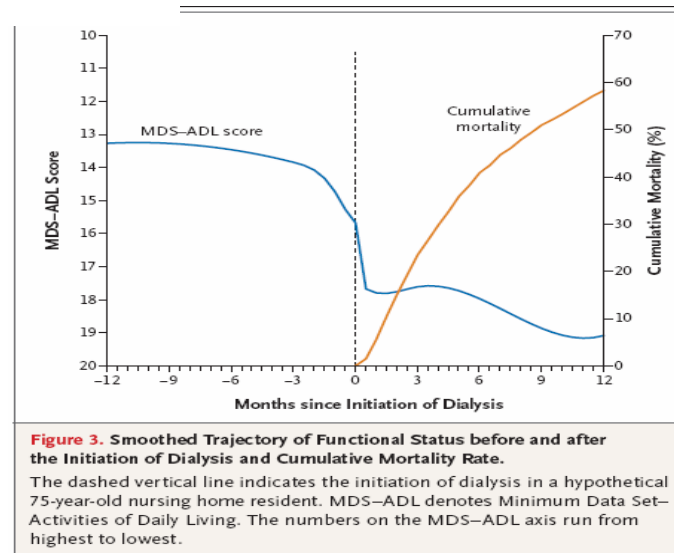


Faller B et al., BMJ Nephrology, 2013

Functional Status of Elderly Adults before and after Initiation of Dialysis

Manjula Kurella Tamura, M.D., M.P.H., Kenneth E. Covinsky, M.D., M.P.H., Glenn M. Chertow, M.D., M.P.H., Kristine Yaffe, M.D., C. Seth Landefeld, M.D., and Charles E. McCulloch, Ph.D.

N Engl J Med 2009;361:1539-47.



Inzidenzalter der Dialysepopulation

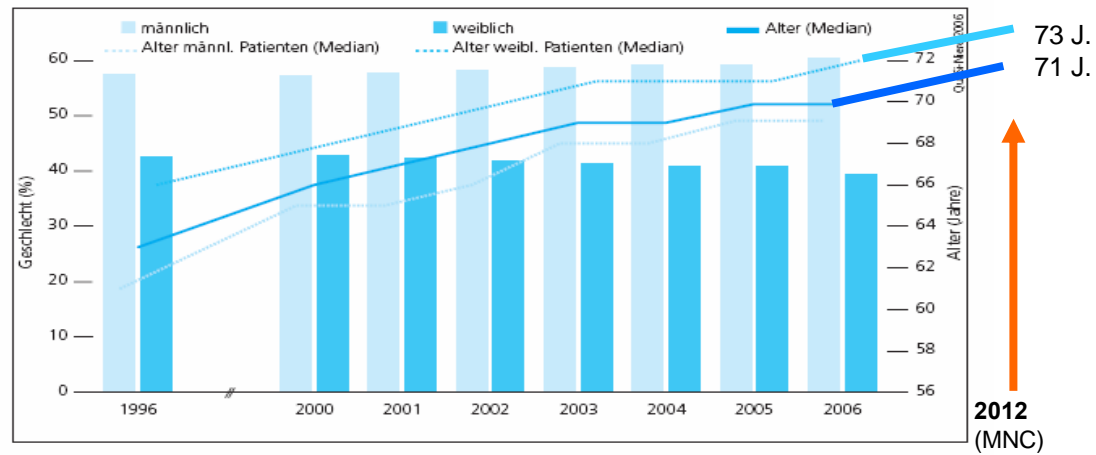
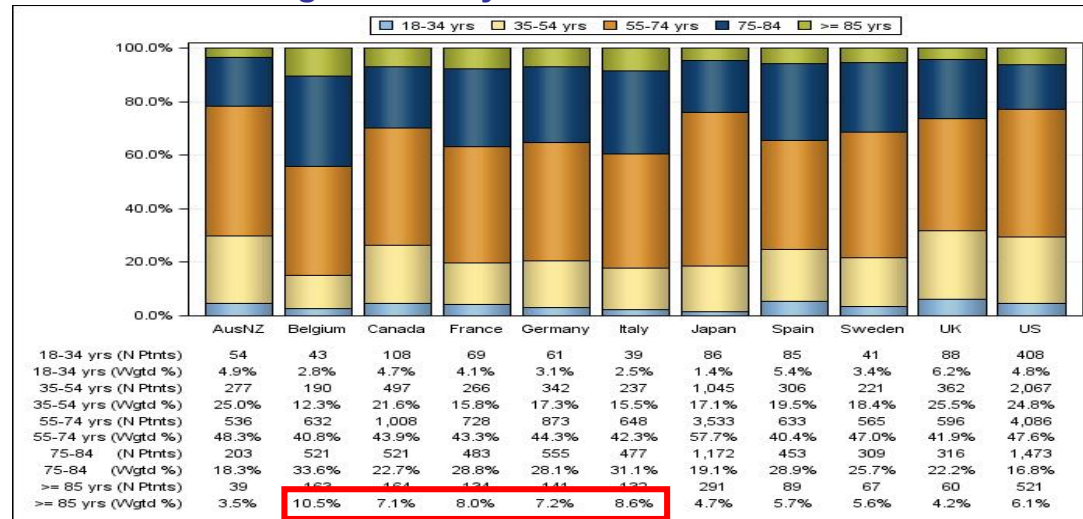


Abbildung 34 Alter (Median) und Geschlecht (%) der gemeldeten Dialysepatienten im Jahresvergleich (Inzidenz)

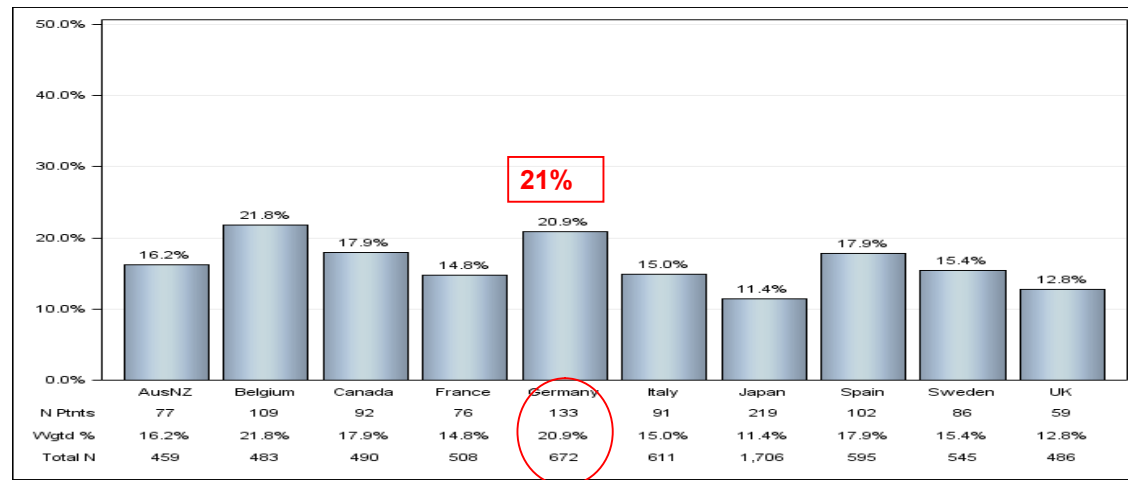
http://www.g-ba.de/downloads/17-98-3495/2013-07-18_MNC-Jahresbericht-2012_mEinleitung.pdf

Deutschland Rang 4 bei Dialyse > 80 Jahre

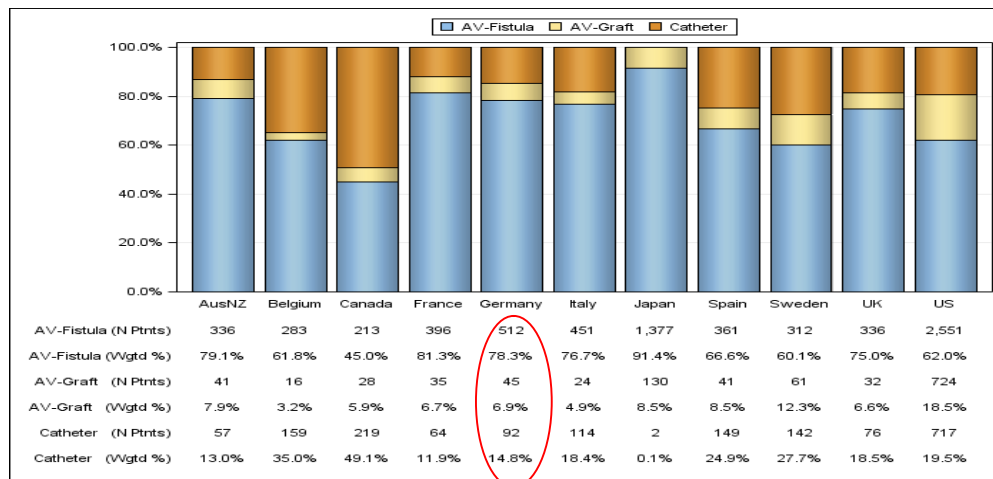


<http://www.dopps.org/annualreport/> Report 2012

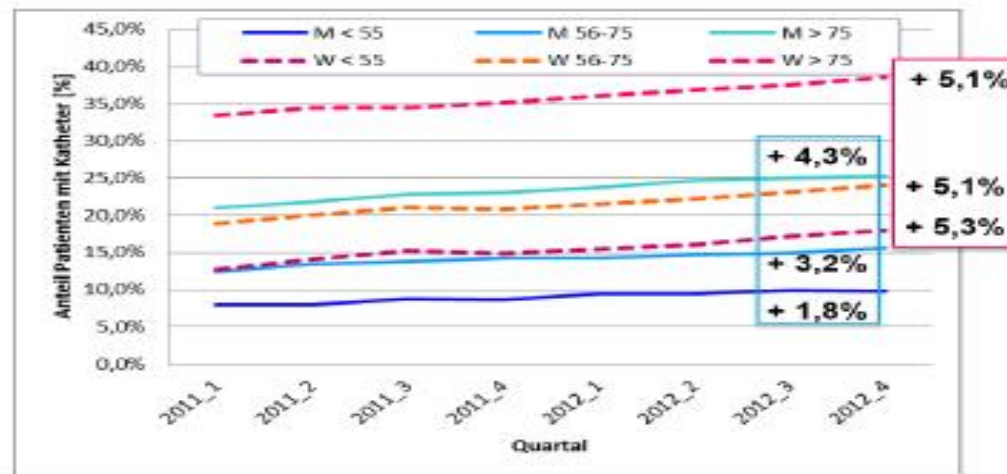
Deutschland Rang 2 cerebro-vask. Erkrank. an Dialyse



Deutschland mit knapp 15% Dialysekatheter im unteren Bereich



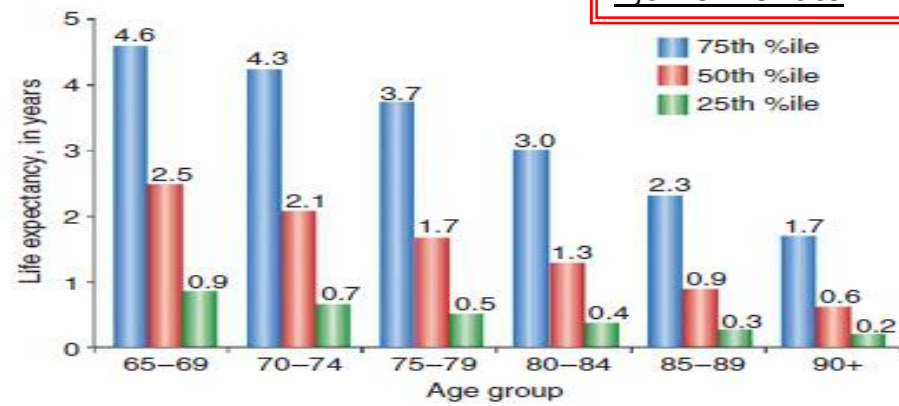
Anteil von Patienten mit Dialysekathetern – QiN-Daten 2011-12



v. Gersdorff et al. DGfN, 2013

Überleben nach Dialyse und Alter

Überleben > 80 J. an
Dialyse in 25. Perzentile
2,5 - 5 Monate



CKD 5 Patienten mit begrenzter Lebensprognose – Einschätzungsmöglichkeiten

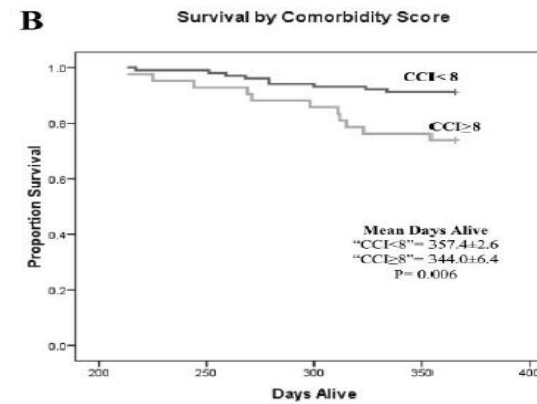
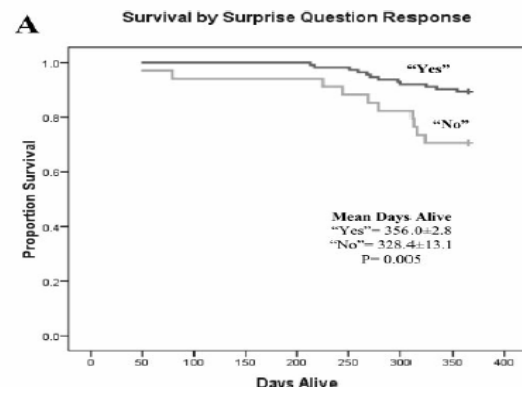
- **Phänotypisierung**
- **Intuitive Einschätzung**
- **Komorbiditäts-Score**

„Phänotypisierung“ von CKD 5-Patienten

Typus	Dialyseoption
Gesund (healthy) go – go´s	gegeben, profitiert von Lebensverlängerung
Verletzlich (vulnerable) slow - go´s	eingeschränktes Überleben, Behandlung kann angemessen sein
Gebrechlich (frail) no - go´s	eher keine Dialyseoption, konservative Behandlung, palliative Therapie

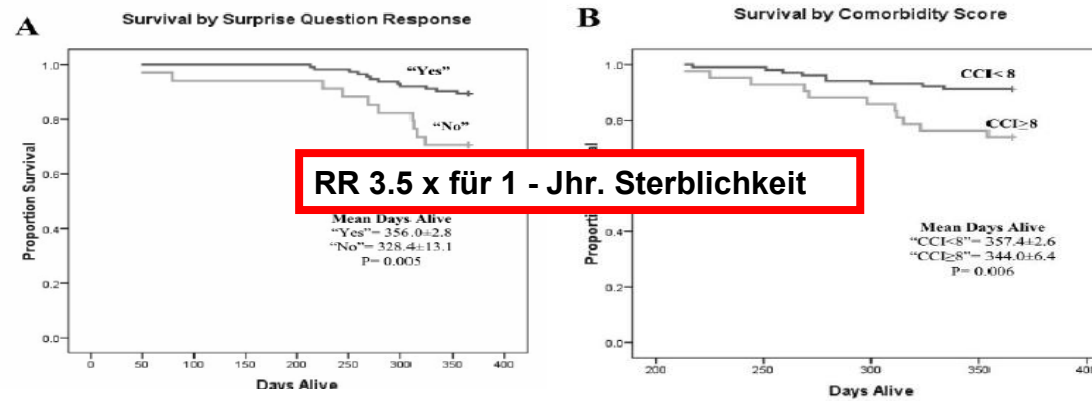
n. Swidler MA, J Gerontol A Biol Sci Med, 2012

„Surprise“ Question



Moss A et al. CJASN (2008) 3: 1379-84

„Surprise“ Question



Moss A et al. CJASN (2008) 3: 1379-84

Charlson-Score: Mortalitätsrisiko mit Punktesystem für Komorbiditäten

■ 1 Punkt

- Herzinfarkt, Herzinsuffizienz, periphere arterielle Erkrankungen, Demenz, Chronische Lungenerkrankung, Lebererkrankung, Diabetes mellitus (ohne Insulin)

■ 2 Punkte

- Hemiplegie, Mäßig schwere und schwere Nierenerkrankung, Endorganschäden, Tumorerkrankung, Leukämie

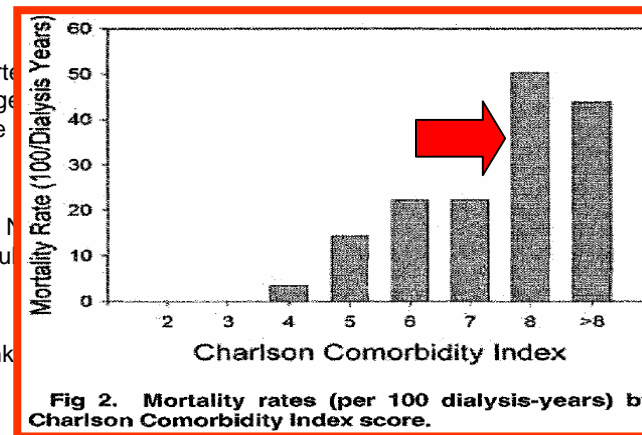
■ 3 Punkte

- Mäßig schwere und schwere Lebererkrankung

■ 6 Punkte

- Metastasierter solider Tumor, AIDS

- Für jede Altersdekade > 40 erhöht sich der Index zusätzlich um einen Punkt



(Charlson et al., 1987)

Prädiktion der 1-Jhr. Mortalität nach Komorbiditätsindizes

Predicting One-Year Mortality: a Comparison of Comorbidity Indices + Age

Instrument (+ age) ^a	Subjects within each level [n (%)]	1-year mortality (%)	Unadjusted		Adjusted ^c	
			Area under ROC ^b curve	95% CI	Area under ROC ^b curve	95% CI
ICED			0.72	0.69–0.75	0.77	0.75–0.79
0–1	545 (31)	9.7				
2	500 (28)	23.2				
3	734 (41)	36.1				
CCI			0.67	0.65–0.70	0.74	0.72–0.77
1	181 (10)	6.1				
2	116 (7)	10.3				
3	767 (43)	21.2				
4	507 (29)	30.3				
5	208 (12)	45.2				
Wright–Khan			0.68	0.65–0.70	0.75	0.72–0.78
1	204 (12)	4.9				
2	787 (33)	18.9				
3	992 (56)	31.7				
Davies			0.68	0.65–0.70	0.75	0.73–0.78
1	301 (17)	9.6				
2	937 (53)	22.8				
3	541 (30)	35.3				

ICED = Index of Coexistent Disease; CCI = Charlson Comorbidity Index; ROC = receiver operator characteristic; CI = confidence interval.

^a Age was added to each model.

Einschätzung Lebenserwartung von CKD 5 D – Pat.

- www.touchcalc.com/calculators/sq

Table 5 Analysis of Maximum Likelihood Estimates									
Variable	Explanation of units for the Hazard Ratio (HR)	DF	Parameter	Standard	Chi-Square	Pr > ChiSq	Hazard Ratio	95% Hazard Ratio Confidence Limits	
			Estimate	Error					
Albumin	HR- per 1 unit increase	1	-1.29603	0.30031	18.625	<.0001	0.274	0.152	0.493
Surprise Question	HR - not surprised vs. surprised	1	0.99602	0.22004	20.4896	<.0001	2.707	1.759	4.167
calcage	HR – per 1 year increase in age	1	0.03068	0.00735	17.4291	<.0001	1.357	1.17	1.567
Adementia_ccipt	HR: Dementia vs. not	1	0.80421	0.35388	5.1646	0.0231	2.235	1.117	4.472
Apvd_ccipt	HR: Periph Vasc Dis vs. not	1	0.63072	0.20934	9.0776	0.0026	1.879	1.247	2.832
Baseline Survival									
			Time	6month	12 month	18 month			
			So(t)	0.57921	0.24999	0.09187			
Predicted survival at time 't' = [So(t)] ^{exp(-lambda*t)}									

Cohen LM et al. CJASN (2010) 5: 72-79

Mini-Review

Dialysis in Late Life: Benefit or Burden

Sarbjit V. Jassal*[†] and Diane Watson*

**Division of Nephrology, University Health Network, Toronto, Ontario, Canada; and [†]Department of Medicine, University of Toronto, Toronto, Ontario, Canada*

As a result of the changing dialysis demographics, nephrologists are increasingly faced with problems traditionally considered to be geriatric issues. The specialty of nephrology has often been seen as using intensive, expensive, and complex technologies for patient care. Dialysis programs have evolved into highly efficient, fast-paced units that accommodate a rapid turnover of patients. They are in direct contrast to geriatric programs, which use geriatric principles to offer simple, multidimensional, holistic care to frail older patients. Finding the balance between nephrology and geriatric skill sets is a particular challenge for up-and-coming nephrologists who have an interest in geriatric nephrology. This mini-review addresses some of the challenges, increases awareness of specific issues, and highlights new opportunities in this field.

Clin J Am Soc Nephrol 4: 2008–2012, 2009. doi: 10.2215/CJN.04610709

Statt: „Zu oft ?“

**„Nicht - aggressive nephrologische
Betreuung am Lebensende“**
(nach Jassal & Watson 2009)