Special Supplement on Peritoneal

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Local Experience:

Battling for CAPD in Pakistan: The Shifa Experience

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Peritoneal Dialysis (PD) is recognized as a patient centered modality for End Stage Kidney Disease worldwide. Compared to In-Centre Hemodialysis, it gives the patients a better quality of life.[1,2] Rather than urgent start, 2 weeks rest after placement of PD catheter is preferred to avoid leaks.

Background:

When I came back to Pakistan in the year 2015; Peritoneal Dialysis (PD) was not being practiced in *the* twin *cities* and the surrounding area of Upper Punjab, Khyber Pakhtun Khawa and Azad Kashmir, which they serve. The reasons for non-existent peritoneal dialysis were the same as all over Pakistan: *Fear of of infections and higher cost as compared to hemodialysis.*

During my time spent in USA, I had worked in a PD program where the risk of PD related infections was very low and quality of life was markedly better than hemodialysis.[3] I refused to settle for hemodialysis as the sole renal replacement modality for those unfortunate enough not to have access to pre-emptive kidney transplant. The 3 major obstacles that I faced in setting up a peritoneal dialysis program were:

1. Convincing patients that this was a viable option for them.
2. Convincing the hospital administration to invest into this "new modality" of dialysis.
3. Procuring Peritoneal Dialysis supplies.

The first patient was placed on peritoneal dialysis at Shifa Int. Hospital, Islamabad in Dec. 2016. He was a 30-year-old male with Kartagener syndrome and ESRD after renal allograft failure and had run out of vascular access for hemodialysis.[4] By using the *Double cuff swan neck catheter* and *Stay safe® set*, we started urgent low volume supine PD. With aggressive PD we controlled his hyperkalemia and then put him on full volume CAPD after 2 weeks.

Due to his genetic disorder, he still gets Respiratory Tract Infections 4-6 times a year but has only had 2 episodes of bacterial peritonitis and 1 episode of Exit site infection. All of the infections were treated on outpatient basis.

After that first patient, a few others came forward who were either losing their vascular access or tired of the in-center hemodialysis routine. A number of patients also came forward who had read about this modality of dialysis online and were seeking a nephrologist who would be willing to prescribe peritoneal dialysis.

For the last 3 years, the PD program in Shifa Int. Hospital has grown steadily. We currently have 2 nephrologists and 3 PD nurses who are providing care to around 36 CAPD patients. We have also inducted 6 pediatric patients on CAPD with the youngest being 7 years old. We have come a long way since 2015 but still there are a few obstacles.

Obstacles and Possible Solutions:

Since the PD supplies are imported, the cost is prohibitive. Sponsorship from government, philanthropists and mainstream insurance companies might enable us to overcome this obstacle. Ambivalence among the general medical community about CAPD as an effective method of renal replacement therapy is another major hurdle. Appropriate education of nephrologists, internists and nurses can surely overcome this issue.
The Overall attitude of Pakistani population towards seeking medical help only in acute sickness rather than maintaining regular follow-up for chronic conditions in general comes to play in taking care of PD patients. There is non-adherence to antiseptic techniques, providing accurate home data of CAPD and missing scheduled clinic visits unless sick. The possible reasons for this behavior could be either lack of insight, trying to cut costs or lack of re-education classes by nephrologists. Because of these reasons, the perception of many nephrologists is that providing care for PD patients is cumbersome as well as underpaid.

Next Steps:

In order to make PD an accepted standard of care in ESRD patients is to raise awareness in the Pakistani Medical Community as well as the chronic kidney disease (CKD) patients. Vigorous training of dialysis staff and nephrology fellowship trainees in peritoneal dialysis through workshops and elective rotations will be crucial.
Setting up telemedicine programs will provide accessibility to CAPD for patients in remote areas. It will also prevent loss to follow-up, early diagnosis and management of complications and improve PD adequacy. Last of all, introducing Initiating

Continuous Cyclic Peritoneal Dialysis (CCPD) will further improve quality of life in patients; prevent burnout in patients and their caregivers. It will also be helpful in patients who are classified as high transporters.

References:

1. Al Wakeel J, Al Harbi A, Bayoumi M, Al-Suwaida K, Al Ghonaim M, Mishkiry A. Quality of life in hemodialysis and peritoneal dialysis patients in Saudi Arabia. Ann Saudi Med. 2012;32(6):570-4.
2. Zazzeroni L, Pasquinelli G, Nanni E, Cremonini V, Rubbi I. Comparison of Quality of Life in Patients Undergoing Hemodialysis and Peritoneal Dialysis: a Systematic Review and Meta-Analysis. Kidney Blood Press Res. 2017;42(4):717-27.
3. Piraino B. Effective Treatment of PD Peritonitis. Clin J Am Soc Nephrol. 2017;12(12):1919-21.
4. https://rarediseases.info.nih.gov/diseases/6815/kartagener-syndrome