Controversy

The dilemma of renal replacement therapy in patients over 80 years of age

Dialysis should not be withheld

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Nephrology societies in every industrial nation are reporting a dramatic increase in the number of elderly patients who require dialysis. In view of this development, it is necessary to examine closely the quality of the results of kidney replacement therapy in this age group.

In this paper, we first report on our own patients over 80 years of age. This will shed light on the quality of haemodialysis, raise questions about the therapeutic process and could be helpful in advising patients and their relatives. In the second part we summarize our personal view, why renal replacement therapy should not be withheld from renal patients even if they are aged 80 years or older.

In our study we included all 83 patients from our dialysis centre between 1981 and 1996 who were over 80 years of age at the start of dialysis treatment. The average survival time of all patients was 25.9 months, and was independent of the age at the commencement of dialysis. The cumulative survival of all our 83 patients after 12 months was 70.5%, after 24 months was 50.3% and after 60 months was 18.5%. However, a comparison of the patients who were first dialysed before 1990 and after 1990 showed a clear difference in the survival rates because survival was better in the 47 patients who commenced dialysis treatment after 1990 compared with the 36 patients who underwent kidney replacement therapy in the previous decade: their 5-year survival was 29% compared with >10% before 1990 [1].

Compared with the survival curves of American dialysis patients (US-RDS data) survival times were clearly higher in our patients over 80 years of age. Our survival curves are almost exactly the same as those of 65-year-old American dialysis patients [2]. We emphasize that in our unit, neither the primary disease nor the comorbidity led to exclusion from the kidney replacement therapy. Any patient will be admitted to the dialysis programme if he or she decides to do so after being thoroughly informed by the physician.

To obtain information about the quality of life, we analysed data on the hospital treatment of those 47 patients who commenced dialysis after 1990. These patients had an average of 4.4 hospital stays/patient with an average duration of 18.4 days. They spent a total of 9.6% of their lives in the hospital. Difficulties with vascular access for dialysis, bacterial infections and cardiac problems were the most frequent reasons for hospitalization.

Is it worth initiating dialysis therapy in patients over 80 years of age? According to our experience, this question can be answered with a definite ‘yes’. However, along with a satisfactory general state of health, the administration of erythropoietin, bicarbonate dialysis and sufficiently long dialysis times (ca. 15 h/week) are prerequisites for obtaining survival rates which make it worthwhile for a very old patient to decide in favour of this very demanding therapy.

Below we discuss in more depth the reasons why, in general, dialysis should not be withheld from patients above 80 years of age. Let us first consider the title of this controversy: “The dilemma of renal replacement therapy in patients over 80”. What is actually a dilemma?

Basically, a dilemma indicates a predicament. It is characterized by a need to choose between two evils (in the original Greek meaning), or in the present case between two possibilities.

If the question is posed “should 80-year-old patients be put on dialysis—‘yes’ or ‘no’?”, it is sensible to ask the question the other way round. What could be the reasons for not providing them with dialysis?

- Is the survival time too short?
- Is the ‘quality of life’ that can be achieved, unsatisfactory?
- Are there so many elderly people above 80 years of age that dialysis posts are taken away from younger patients?
- Do financial constraints make age a matter of rationing?

As far as survival times on dialysis are concerned, our data as well as those of other European dialysis centres document that the results provide no rationale for...
withholding dialysis treatment, not even if the life expectancy of the over-80-year-old dialysis patient is compared with that of younger dialysis patients. It is true, our data reveal that 80-year-old dialysis patients have a life expectancy of only 36% of age-matched healthy control individuals. But, the remaining life time is, using such calculations, significantly higher than that of 40- to 60-year-old dialysis patients as their life expectancy is only 16% of that of healthy peers [2].

Let us examine whether quality of life is unsatisfactory in 80-year-old dialysis patients. The results of several studies are quite encouraging in this respect. A study performed recently in Berlin yielded amazing results: 80-year-old dialysis patients were not only very satisfied with their lives on dialysis, but also had less difficulty accepting the adjustments required for life on dialysis than did younger patients. It is also interesting that 80% of the over-80-year-old dialysis patients would recommend dialysis treatment to patients of the same age and only 12.5% would recommend that patients of the same age refuse dialysis treatment [3].

Naturally, it could be argued that the number of the dialysis patients aged over 80 years is so high that dialysis posts will be taken away from younger people. The very elderly represent about 12% of the patients in our dialysis centre. According to the US-RDS data, 19.9% of dialysis patients are above 75 years of age [2]. It is safe to assume that about 15% of the patients who begin dialysis are over 80 years old. Is that an alarming figure?

The one remaining, and possibly most important argument, is cost. Of course costs can be reduced, if as a rule, elderly patients are excluded from the treatment. If 15% of the currently assumed 300,000 dialysis patients worldwide, namely those over 80, were no longer treated, there would be 45,000 fewer patients. Multiply this figure by the number of dialysis treatments needed in the course of a year and you will arrive at the result that more than 2 billion dollars could be saved worldwide. It should be pointed out, however, that despite their advanced age, the elderly dialysis patients cost little more than younger dialysis patients. US-RDS data show that the patient over 80 years of age causes only 11.1% more costs than a younger patient [2]. Furthermore, if the total number of patients in an age group is related to the total cost, it is amazing to note that the care of dialysis patients over 75 years of age requires less money (i.e. only one-third) than the treatment of 20–40-year-old individuals [2]. Such calculations are dangerous and problem-ridden, the more so because they cannot be limited to dialysis. By necessity they will end in a discussion about allocation of resources for instance, “If I dialyse one 80-year-old patient, I could not treat 100 patients with diuretics or insulin”. It is beyond the scope of this controversy to discuss in depth the issue of whether affluent Western societies can ‘afford’ to treat the very elderly—but in the end it is matter of how much a community is willing to spend on its health-care system.

Discussion of the problems we have broached would be incomplete unless theological, ethical and philosophical aspects were considered. We wish to conclude by dealing with some of these issues.

For the one who regards medicine as a Christian vocation, medicine implies the care of the sick, the poor, the dejected and of course, the elderly. At the extreme the notion of beneficence can be extended to the point of self-interest,—at least that is the ‘hard’ message of the Gospel, which states that some unselfish sacrifice is required, as in the parable of the Good Samaritan (St. Luke 10:25) [4].

The economically minded will argue: health care must be rationed and a just basis on which to ration is age. Thus health care would be preferentially provided to the young; the elderly would have the least priority. The rationale given for this ranking of priorities, young first, elderly last, is the argument that the elderly have already lived a normal lifespan. Further arguments include the following. (i) The only way life for the old is meaningful is if the old serve the young. (ii) The old ought to serve the young, for example, by serving as moral exemplars who surrender claims on lifesaving services in favour of the young. (iii) The old can be compelled through age-rationing measures to carry out their obligations to the young [5].

These arguments are both unsound and invalid. There is no one way for the old to find ‘meaning’ in their lives. Of course, serving the young might be one way. But there are other ways, for example, some find ‘meaning’ in their old age by serving the old. In a culturally diverse society we are likely to differ considerably in our views about what conveys ‘meaning’ to old age. Similarly, if we look at other cultures, we shall presumably find similarly varied views about the ‘meaning’ of life in old age.

Hence age rationing is in conflict with the underlying principle that persons have the right to self-determination in matters of their own death. This principle cannot be overridden if one can achieve distribution of resources in accord with the demands of justice and yet preserve voluntary choice.

The patient must be informed about the treatments offered. Specific recommendations will help him or her to decide whether to accept treatment. The patient must be made aware of the limited life expectancy and the limited quality of life that will be provided, including the many hospitalizations that may be necessary. The final decision, however, must be patient’s alone, and there must be no pressure to make choices on the grounds of financial limitations [6].

References