Outcome of renal replacement therapy in the very elderly

Sir,
Munshi et al. recently reported on the outcome of dialysis patients over 75 years of age [1]. In a retrospective analysis they found that the 1-year survival in this age group was 53.5% and that the very elderly patients spent 20% of their time in hospital. They concluded that 'very elderly ESRD patients have a very poor outcome and, since they are the largest growing group of RRT patients, this has important implications for future health policies' [1]. Maybe this is true for Leicester, UK. We have already reported in 1996 (also in NDT) that our patients who were 80 years of age at the start of dialysis had a 5-year survival of 29%, in addition they spent a total of 9.6% of their lives in hospital [2]. In an additional report in 1999 (again NDT), we examined the ethical aspects of the dilemma of renal replacement therapy in patients over 80 years of age [3]. It might be of interest for the Leicester group to learn that the 1-year survival of our patients commencing dialysis over 85 is 65% (unpublished data).

There are basically two reasons why the report from Leicester is disturbing. First, the authors seem to ignore previous reports, at least those papers which have been published in the same journal where they have submitted their manuscript. Second, and this criticism is more important, their results are not typical or representative for the survival of elderly patients. In our opinion their data reflect merely poor dialysis quality. It is certainly necessary to discuss whether or not renal replacement therapy should also be provided for the very elderly. However, as this issue is an especially sensitive one, all available data has to be considered before any recommendations should be expressed.

St. Joseph-Krankenhaus Berlin
Medizinische Abteilung II
Berlin
Germany

Klaus Schaefer
Dietrich von Herrath
Bernhard Röhrich

Reply

Sir,

Schaefer et al. compare their more favourable outcome in very elderly patients treated by dialysis with our data and suggest the difference is due to 'poor dialysis quality'. They offer no evidence to support this last statement. The data they quote were published initially as a dialysis news item in 1996 [1] and large parts of this article were then republished in 1999 [2]. While acknowledging our failure to reference these publications, we believe Schaefer and colleagues' comments are fundamentally flawed. The survival rates they quote are based on data excluding all deaths occurring within 3 months from starting dialysis, while our published data includes all patients over 75 starting dialysis for chronic irreversible renal failure. If we exclude all deaths within 3 months from our analysis, our 1-year survival is 68.7% which is not significantly different from Schaefer's data (70%) or from USRDS data from 1993 for 75–79-year-olds (66%) which also excludes death within 90 days. We congratulate Schaefer et al. on their good outcomes. Their 5-year survival rate of 29% for patients over 80 years means that this group have a survival coming close to that of the general population of this age not on RRT. The annual death rate in the UK for the general population ranges from 5.7% for an 80-year-old female to 13.6% for an 85-year-old male [3].

Their 1999 article is published along with a commentary by Mallick and El Marasi [4]. These authors emphasize the importance of biological age and suggest that most dialysis centres have elderly patients whose quality of life and survival on dialysis are poor. Nowhere in our paper do we advocate withholding RRT from elderly patients on the basis of age alone. The challenge for nephrologists is to help patients and their families make appropriate choices about renal replacement therapy in order to 'add life to years rather than years to life'.

We are not complacent about our ability to provide optimal care for elderly patients with end-stage renal failure within the UK National Health Service. We will continue to strive to improve our resources and services for the treatment of renal failure so that those elderly patients who can will benefit from RRT.

On behalf of:

Departments of Nephrology and Medicine for the Elderly
Leicester General Hospital
Leicester
UK

N. Vijayakumar
N. A. Taub
H. Bhullar
T. C. N. Lo
G. Warwick