Is a major psychiatric illness a contraindication to chronic dialysis?

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The use of an artificial kidney was first commenced in the mid 1940s for the treatment of acute renal failure. Only from the early 1960s were patients with end-stage renal disease (ESRD) accepted for chronic haemodialysis therapy. Initially, those accepted for chronic dialysis were, in general, in excellent medical condition (i.e. without any co-morbidities) apart from their renal failure. They, thus, tended to be young with no evidence of systemic disease. The advent of the external shunt followed by the native arteriovenous fistula in the late 1960s established haemodialysis as a feasible long-term maintenance therapy. However, financial considerations, lack of professional personnel and primitive technology resulted in limited availability of chronic dialysis. One of the major contraindications for acceptance to dialysis was age. In the early 1970s, the average age of dialysis patients was 30–35 years. Over the next three decades, the limitations of acceptance onto a chronic dialysis programme were gradually dissipated. This was mainly due to an increased number of trained dialysis practitioners (both physicians and nurses) and improved technology. As a result, the dialysis patient population underwent a considerable change. In 1999, 47% of the patients entering the Medicare ESRD programme were aged >65 and 23.4% were >75 years [1]. The mean age of dialysis patients in our unit is 66–67 years. Co-morbidity is widespread consisting of multiorgan involvement by diabetes mellitus, generalized atherosclerosis, congestive heart failure, systemic disease and even malignancy (either ongoing or in remission).

The treatment of chronic illness, particularly when it demands dietary and/or fluid restrictions, requires a high degree of patient co-operation, discipline, insight and, last but not least, a strong family support. Without these essentials, the chance of long-term survival is vastly diminished. Depression has been documented as the most frequently encountered psychological problem in (ESRD) patients and has been correlated with both morbidity and mortality in these patients [2]. Undoubtedly, ESRD and/or dialysis eventually lead to physical and at times mental incapacitation [3]. Dialytic therapy represents a unique situation whereby life is maintained artificially but is severely restricted and unsatisfying coupled to an ever-imminent fear of immediate death and a feeling of total dependency on the dialysis machine. Patients are often frustrated, humiliated and angry. The anger is not infrequently vented out at the dialysis staff expressed as multiple complaints and/or verbal confrontations. Of note, as the average age of dialysis patients increases, a greater percentage of these patients are retired pensioners. They are, therefore, relatively less concerned with financial problems, family commitments or the need...
for personal achievements having, hopefully, fulfilled these aspirations prior to retirement [4]. Consequently, the elderly dialysis population is less prone to depression tending instead to martial its efforts at taking on life on dialysis. This is in stark contrast to the general elderly population in which solitude and depression are very common.

Experience with dialysis in patients suffering from major psychiatric disorders is limited. Haemodialysis was once advocated as a treatment for chronic schizophrenia based on a few reports with a small number of patients [5]. Subsequently, however, no improvement was documented in schizophrenic patients on chronic dialysis [6]. The essentials mentioned above (patient co-operation, discipline, and insight) are obviously lacking in the majority of psychotic patients. Nevertheless, one may encounter psychiatric patients whose previous psychotic behaviour has been well controlled by modern day psychiatry. These patients who to all intents and purpose function normally and who may possess family and communal support warrant a reappraisal by the dialysis community regarding chronic dialysis in major psychiatric disturbances. This issue has never been debated in nephrological conferences nor are there any existing guidelines (the latter also being true for the general population). Dialysis obligates written patient or legal guardian consent. Health policy in Israel mandates that every ESRD patient be afforded dialysis regardless of his mental and/or general health status. The only accepted medico-legal reason for declining dialysis is the patient’s written refusal subject to his being judged of sound mind by a trained psychiatrist. Although, at times, differences as to the patient’s suitability for dialysis (or the futility, thereof) may arise among the attending staff, or even between the psychiatrist and the nephrologists, on being determined capable of deciding his own fate, the patient’s desire is binding. This may appear to simplify matters as far as the decision to dialyse is concerned. However, intra-departmental conflicts and frustrations do develop. Nevertheless, dialysis is performed as long as the patient so wishes. If the patient’s condition deteriorates for whatever reason into a state where he is no longer deemed capable of decision, an ethics committee is then convened to decide on dialysis continuance or cessation. Difficulty may arise when opinions regarding dialysis treatment differ between the patient and the guardian. In most instances, the guardian opts for treatment while the patient refuses. Forceful subjection of the patient to dialysis is an alternative but hardly a viable one. In exceptional circumstances such as an acute haemodialysis, sedation or full anaesthesia may be considered. Chronic dialysis, however, mandates a basal level of patient cooperation and requires active intervention of the psychiatric team to ensure that this goal is obtained. We have, as yet, not encountered the reverse situation, that is patient’s willingness for dialysis in the face of the guardian’s refusal. Such a scenario is within the realm of possibility and should it occur would entail extremely complex ethical and medico-legal aspects.

ESRD patients with active psychiatric illnesses are, as a general rule, not considered suitable candidates for transplantation. The lack of discipline particularly as it applies to patient compliance with medications constitutes a prohibitive deterrent. In a USA survey, 92, 67, and 73% of heart, liver and kidney transplant programmes, respectively, viewed active schizophrenia as an absolute contraindication to transplantation. Controlled schizophrenia was considered an absolute contraindication in 33, 15, and 7% of the respective heart, liver and kidney programmes [7]. Although there are anecdotal reports of actively psychotic patients who have been successfully transplanted [8], in reality the only therapeutic option for these patients is haemodialysis. Once accepted onto a chronic dialysis programme, the time invested by the staff in these patients (and we are talking about the stable or in remission patients) is far greater than that devoted to the general dialysis population. This results in an added burden to the staff, a burden which is mainly borne out by the dialysis nurses. Currently accepted practice is for every dialysis unit to have an attending psychologist/psychiatrist on constant call. It is the job of the psychiatric team to care to the well being not only of the patients but also to that of the staff. Commonly, however, due to understaffing, adequate psychiatric support is lacking.

There is no information available as to the number of dialysis patients with major psychiatric disturbances in Israel. In our haemodialysis unit, out of a total 132 patients we currently dialyze three chronic schizophrenics, one bipolar disorder (ESRD due to lithium intoxication) and one mentally retarded patient. Two other schizophrenics have died, one in pulmonary oedema as a result of uncontrollable interdialytic fluid gain (in excess of 7 kg), the other due to severe malnutrition for which any investigation or intervention was refused. This latter patient had, however, been dialyzed for seven years prior to his demise. Overall, the course of these patients on dialysis was marked by alternating periods of full co-operation to those of complete non-compliance coupled with aggressive behaviour, both verbal and physical, towards the staff. In general, the period of commencement of chronic dialysis is usually the tempestuous one. With the passing of time, a period of adjustment is evident, characterized by a gradual acceptance of therapy and a decreased frequency of aggressive spells. One of our schizophrenics is now even a candidate for transplantation. Her initial period on dialysis was notable for violent temper tantrums. She had to be escorted from a closed psychiatric ward to the unit by a guard. At present, after two years of dialysis, she is docile and co-operative.

Finally, we have addressed the issue of chronic dialysis, specifically haemodialysis, in patients with major psychiatric illnesses. It seems to us that peritoneal dialysis, whether it be continuous ambulatory (CAPD) or automated (APD), being a home
therapy intended to be performed by the patient himself, would place too much of a responsible burden on these particular patients.

Our experience has shown that the establishment of a multidisciplinary team composed of psychiatrist, nephrological personnel and social workers enables the extension of chronic dialytic therapy to patients with major psychiatric illnesses. Obviously, every such patient will have to be thoroughly evaluated and his suitability for chronic dialysis individually assessed. Although this endeavour undoubtedly demands the investment of considerable time and resources by all involved, the satisfaction gained upon successful treatment is well worth the effort. It is time that both the psychiatric and nephrological communities openly address this issue.

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