



Assisted Peritoneal Dialysis: A Missed Opportunity in Integrated Care for Patients on Dialysis

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AT THE EUROPEAN Renal Association (ERA) 2026 Congress, Irma Tchokhanelidze, Tbilisi State Medical University, Georgia, presented a discussion on the importance of considering an integrated approach to dialysis care.

INTRODUCTION

With the increasing international burden of chronic kidney disease and its related care, the provision of optimal dialysis care is becoming increasingly challenging. The International Society of Nephrology (ISN) advocates for a goal-directed patient journey and an integrated approach to dialysis care, with patient choice in treatment decisions being strongly emphasised.^{1,2} The SONG initiative similarly highlights that patient outcomes cannot solely be reflected by biochemical markers or even patient survival, but that dialysis modality selection must provide positive patient-centred outcomes such as quality of life, flexibility of therapy, and patient autonomy.^{3,4} Tchokhanelidze framed her discussion in terms of 'What should the approach to dialysis modality selection be?', highlighting the importance of how the timing and combination of dialysis modalities can bestow significant benefits for patients.

The particular focus is on maintaining patients' quality of life benefits relating to home dialysis modalities, without

compromise on clinical outcomes. Nadeau-Fredette et al.⁵⁻⁷ have demonstrated in Canadian and ANZDATA cohorts that an integrated home dialysis model of peritoneal dialysis (PD), followed by timely direct transition to home haemodialysis (HHD) when PD is failing, has superior survival and lower risk of transfer to in-centre dialysis compared to initial treatment with HHD, when controlled for dialysis vintage and despite a higher burden of comorbidity in the PD exposed patients. The expected drivers of this benefit are PD-related preservation of residual renal function and deferring the need for vascular access. The speaker also highlighted that PD can be a longer-term dialysis modality in selected PDOPPS countries where transplantation rates are lower, for example, a median PD vintage of 3.2 years in Japan versus 1.7 years in the UK.⁸

OPTIMISING HOME DIALYSIS INTEGRATION

Maximising home dialysis uptake through a strategic and structured approach, as described by the International Home

Dialysis Consortium, has clear lifestyle benefits for patients and improved clinical outcomes, such as a lower risk of acute hospitalisation after the long in-centre HD intra-dialytic gap.^{9,10} There is also the favourable healthcare economics and environmental sustainability compared to in-centre HD to consider. Unfortunately, global uptake of home dialysis remains low, with New Zealand being the sole country reporting >30% home dialysis utilisation.¹¹ Missed opportunities are occurring in patients with a stated preference for home therapies, with one Canadian study of 1,845 incident patients reporting that 320 (17.3%) patients were 'missed' and very few patients had an absolute contraindication to both PD and HHD.¹² Furthermore, many patients are being recorded as unsuitable for home dialysis without clear contraindications being recorded or without being suitably assessed. Given a choice with shared decision making, a high proportion of this cohort will opt for home dialysis.¹³ Tchokhanelidze then moved on to discuss the key barriers to home dialysis utilisation, divided into person-related, centre-related, and system-related barriers.¹⁴ In reality, absolute contraindications to home dialysis are considered rare, and

relative contraindications are reported to be more dependent on provider variability in experience, prejudice, enthusiasm, and available support for patients and their carers.¹⁵ The Canadian START initiative demonstrated clearly that with resources and a structured framework, home dialysis providers can positively impact the number of patients on dialysis treated with PD within 6 months of dialysis initiation.¹⁶ The speaker concluded that "registry and cohort studies demonstrate comparable or better outcomes when home therapies are used in integrated pathways, yet many patients miss opportunities for home dialysis and the data [...] highlight that system, centre, and patient factors determine who gets offered home therapies."

“Unfortunately, global uptake of home dialysis remains low, with New Zealand being the sole country reporting >30% home dialysis utilisation”



ASSISTED PERITONEAL DIALYSIS: A MISSED OPPORTUNITY

One of the key issues raised by Tchokhanelidze for the wider nephrology community in many jurisdictions to consider was the person-related barrier of 'insufficient social and family support', which can be framed through the lens of access to an assisted PD (asPD) programme. A high proportion of patients with no absolute contraindication to PD, particularly the elderly and more frail patients with chronic kidney disease, have physical, cognitive, or behavioural issues that preclude them carrying out many of the daily tasks required for self-care PD.¹⁷ Patients with available family or partner support may get assistance to be safely offered PD, although PD caregiver burnout in this setting is unfortunately high and risks technique failure.^{18,19} For those without community supports, in-centre HD becomes the inevitable default, and the many medical, psychosocial, and economic benefits of PD are forfeited. Community asPD programmes are in operation in many countries globally, varying from large national or regional government-funded programmes in France or Canada, to smaller single centre programmes in the UK, Denmark, and Brazil funded through trusts, research grants, or private entities.²⁰ These programmes vary in terms of the type of staff conducting the care, the location and duration of care provided (long-term versus respite care), and the number and setting of daily visits. In addition to the obvious quality of life benefits for patients who can undergo home dialysis, there is a strong economic argument for providing asPD, with reports in France and Canada showing cost-saving with asPD versus the default in-centre HD.^{21,22} Studies have shown that the availability of asPD can increase incident PD use and also reduce the risk of prevalent PD transfer to in-centre HD.^{23,24} Nurse-assisted PD is also associated with reduced technique failure compared to family-assisted PD and a protective effect from PD-related peritonitis.^{25,26} The enlightening European Assisted PD survey in 2022 reported on the wide variety of asPD programmes in operation, with valuable personal and national clinician

experience, data on the types of PD assistants employed, funding models, and the barriers to growth in 13 countries.²⁷ Of these, there were six countries where family or private-carer asPD was in use, but with no formal public health-system funding or reimbursement for asPD (Austria, Finland, Ireland, Italy, Portugal, and Spain). The lead authors lament the overall lack of development in asPD services since the early reports of its implementation in Europe and propose a call to action focusing on key recommendations such as improving education of patients and providers on the benefits of PD, establishing national funding programmes for asPD, expanding the pool of PD assistants to non-healthcare professional staff with a standardised training curriculum, and defining clear protocols for establishing asPD programmes in renal units.

“Allowing more patients to access asPD will confer to them clinical and quality of life benefits of home dialysis”

CONCLUSION

The call to action to make access to asPD a reality is strongly in line with the conclusions of Tchokhanelidze's discussion on the benefits of an integrated approach in the care of patients on dialysis. Specifically, allowing more patients to access asPD will confer to them clinical and quality of life benefits of home dialysis, improve dialysis vintage, and reduce the demand for in-centre HD to an ever-increasing cohort of patients. Providing timely and equitable access to asPD, even in countries with already well established home dialysis programmes, will require strong clinical leadership and sustained engagement with national health authorities to provide appropriate funding, staffing, and training.

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