End Stage Renal Failure - Dilemmas and Hope!

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The true incidence and prevalence of end stage renal failure (ESRF) cannot be estimated. Generally, there is a wide variation in the incidence and prevalence rates recorded by the different national and international registries. Close collaboration between various centres, covering large populations has become a pre-requisite for progress in medicine. The ERA-EDTA (European Renal Association -European Dialysis and Transplant Association) Registiy was the first to accumulate detailed information on the demography of renal replacement therapy. This registiy covers all areas of Europe, including bothEastem and Western countries as well as those surrounding the Mediterranean coast. For many years it remained the only source of documentation available worldwide and helped thus shape this rapidly expanding young speciality[1]. Similar other registry programmes developed in other parts of the world including USRDS (United States Renal Data Systems)[2].

The validity of the overall demographic data depends critically upon the return of reliable infonnation as well as criteria for inclusion orexclusione.g., patients who die in first few weeks of commencing dialysis may be recorded by some centres and not by others. This is particularly relevant when comparing European data with those from United States as USRDS excludes patients dying in the first 90 days[2].

The use of advanced technology integrated into the system will permit the regisUy to step forward into the 21st century. Shalom Mendel[3] has introduced a “New Comprehensive Computer Software System (NCSS)” the major elements of which are The Data, The Software and The Hardware. The philosophy of NCSS must continue to follow the principle ‘by physician for physician’. Registry of ESRF patients with such computerized programmes will help in estimating the true incidence or prevalence and the need of renal replacement therapy.

The present state of renal replacement therapy relies on two modalities, Dialysis and Transplantation. Dialysis is a life prolonging treatment without possibility of reversing the underlying disease. Although prognosis for patients withESRF treated by dialysis may have improved in recent years, mortality rates remain high.

Transplantation which is now a grown up technology, witha generally excellent outcome in most of the patients is an accepted form of ultimate renal replacement. Extensive scientific investment towards understanding of immunology and development of new immunosuppressive drugs has resulted in much better graft survivals.

Many patients may die of ESRF without receiving treatment. Reasons why patients did not receive renal replacement therapy may include late diagnosis and referral to renal care units, selection of patients based on co-mothidity factors and lack of places for treatment.

Timely referral of patients with chronic renal failure to a nephrologist optimizes conservative management, including dialysis planning. Unfortunately many patients suffer a needlessly rough journey on the road to dialysis. Delayed referral leaves patients beginning dialysis with biochemically more advanced uremia, more severe acidosis and anemia, poor nutritional status and inferior control of blood pressure and hyperparathyroidism.

Similarly on the front of transplantati5n the problem of organ shortage is chronic, persistent and shows no tendency for improvement. InUS eachyear the waiting list increases by over 1000 with a backlog of 25,000 patients[4].

Health care professionals, providers of medical services and those involved in health policies need to continue finding cost effective alternatives to guarantee that the increasing number of End Stage renal

failure (ESRF) patients demanding treatment will actually receive it.

References

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