Current Status of the Implication of the Clinical Practice Pattern in Hemodialysis Prescription in Regular Hemodialysis Patients in Egypt (North Sohag)

Protocol of Thesis

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By

Eman Mofdy Karmy

(M.B.B.,CH.,) Assuit University

Medical Diplomat (Ain Shams University)

Under Supervision of

Prof. Dr. Yasser Soliman Ahmed

Professor of Internal Medicine and Nephrology
Faculty of Medicine – Ain Shams University

Dr. Hisham Atef AboEllel
Professor assistant of Internal Medicine and Nephrology
Faculty of Medicine – Ain Shams University

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LIST OF ABBREVIATIONS

Abbrev.	Full term
AVF	arteriovenous fistula
AVG	arteriovenous graft
BMI	Body mass index
PEM	protein-energy malnutrition
CAPD	continuous ambulatory peritoneal dialysis
CHF	Congestive heart failure
CKD	Chronic kideny disease
CKD5	chronic kidney disease stage 5
CLD	Chronic liver disease
CMS	US Centers for Medicare and Medicaid Services
CPG	clinical practice guidelines
CSN	Canadian Society of Nephrology
CVC	Chronic venous cathter
CVD	Cardiovascular disease
DM	Diabetus mellitus
DOPPS	Dialysis outcome and practice pattern study

ERA-EDTA	the European Renal Association-European Dialysis and Transplantation association
ERT	the Evidence Review Teams
ESRD	End stage renal disease
GBD	Global Burden of Disease
GFR	Glomerular filtration rate
GraDe	Grades of recommendation assessment, Development, and evaluation
Hb	Hemoglobin
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human immunodeficiency virus
HD	Hemodialysis
HTN	Hypertension
HR	Hazard ratio
IV	Intravenous
K/DOQI	Kidney Disease Outcome Quality Initiative
KDIGO	Kidney disease improving global outcomes
KHA-CARI	The Kidney Health Australia-Caring for Australasian with Renal Impairment
MBD	Mineral and bone disorder
MIA	Malnutrition -Inflammation atherosclerosis (MIA) Syndrome
MICS	'malnutrition–inflammation complex syndrome'
MOH	Ministry of health
NCDs	Noncommunicable diseases
NKF	National Kidney Foundation
PEM	Protein energy malnutrition
pmp	Per million population
PTH	parathyroid hormone
PVD	Periferal vascular disease
RA	The UK Renal Association
RCTs	Randomized clinical trials

RRT	Renal replacement therapy
SPSS	Statistical package for special science
VA	Vascular access

الوضع الحالى لأشكال الممارسه الاكلينكيه المتبعه لوصفات الاستصفاء الدموى لدى مرضى الاستصفاء الدموى فى مصر (شمال سوهاج)

رسالة

توطئة للحصول على درجة الماجستير
فى أمراض الكلى

مقدمة من

د/ ايمان مفدى كرمى جيد

بكالريوس الطب والجراحة

دبلوم أمراض الباطنة – جامعة عين شمس

تحت إشراف

أ.د/ **ياسر سليمان أحمد**
أستاذ أمراض الباطنة والكلى
كلية الطب – جامعة عين شمس

د./ هشام عاطف ابوالليل
مدرس أمراض الباطنة و الكلى
كلية الطب – جامعة عين شمس

كلية الطب
جامعة عين شمس
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INTRODUCTION

Chronic kidney disease (CKD) is a worldwide public health problem. According to the World Health Report 2002 and Global Burden of Disease (GBD) project, diseases of the kidney and urinary tract contribute to the global burden of diseases, with approximately 850,000 deaths every year and 15,010,167 disability-adjusted life years. ***(http://www3.who.int/whosis/menu.cfm?path=evidence,burden&language=english.)*** They are the 12th cause of death and the 17th cause of disability, respectively. The global incidence and prevalence of CKD, however, may be underestimated by these data for a number of reasons.

Studies examining the link between research evidence and clinical practice have consistently shown gaps between the evidence and current practice. Some studies in the United States suggest that 30%-40% of patients do not receive evidence-based care, while in 20% of patients care may be not needed or potentially harmful. However, relatively little information exists about how to apply evidence in clinical practice, and data on the effect of evidence-based guidelines on knowledge uptake,

process of care or patient outcomes is limited ***(Locatelli et al., 2004)***.

Appropriately then, the care of dialysis patients has been the prime focus of nephrology, particularly after the widespread availability of maintenance dialysis when it became evident that mortality of dialyzed patients was high and their quality of life far from adequate***(Eknoyan et al, 2002).***

Guidelines practiced on anemia and actual practices are much different with different places and patients according to treatment. Moreover, in individual countries and individual units within countries local circumstances relating to economic conditions; organization of health care delivery or even legal constraints may render the immediate implementation of best practice guidelines difficult or impossible. Nevertheless, they provide a goal against which progress can be measured ***(Locatelli et al., 2004)***.

Compliance with clinical guidelines is an important indicator of quality and efficacy of patient care, at the same time their adaptation in clinical practice may be initiated by numerous factors including; clinical experts, patient performance, constrains of public health policies, community standard, budgetary limitation and methods of feeding back information concerning current practice ***(Cameron, 1999)***.

End-stage renal disease (ESRD) is one of the main health problems in Egypt. Currently, hemodialysis represents the main mode for treatment of chronic kidney disease stage 5 (CKD5), previously called ESRD or chronic renal failure ***(Afifi , 1999)***

Although hemodialysis is often used for treatment of ESRD, no practice guidelines are available in Egypt. Healthcare facilities are seeking nowadays to develop practice guidelines for the sake of improving healthcare services ***(Ministry of Health and Population,1999)***

AIM OF THE WORK

To study the pattern of current clinical practice in hemodialysis prescription in regular hemodialysis patients in Egypt and to compare this pattern with standard international guidelines in hemodialysis prescription, stressing on anemia, bone disease management and adequacy of dialysis.

ESRD burden in developing countries

One potential outcome of chronic kidney disease (CKD) is end-stage renal disease (ESRD), requiring costly renal replacement therapy in the form of dialysis or transplantation. Although the incidence of ESRD shows signs of leveling off in developed countries, perhaps in part because of increased awareness of CKD, no such trend is seen in developing countries or minority populations. Over 2 million people now require renal replacement therapy to sustain life worldwide, but this likely represents less than 10% of those who need it ***(Codreanu, 2006)***

Chronic renal failure is a devastating medical, social, and economic problem for patients and their families. The availability and quality of dialysis programs largely depend on the prevailing economic conditions, the political-social structure, overall health care facilities, and the health care funding strategies of various countries. Large disparities separate the socio-economic structures of various countries, especially the developed and the developing countries. In the developed world, health care is generally available, whereas the vast population of people living in developing countries do not have access to even basic amenities like sanitation and safe drinking water ***(REPORT, AD: 2000, in The World Bank, 2000, New York, Oxford).***