DOMESTICO

De lessen uit DOMESTICO

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Internist-nefroloog

Deventer Ziekenhuis

Deventer ziekenhuis

Disclosure A. v. Eck v.d. Sluijs

(potentiële) belangenverstrengeling	Geen / Zie hieronder
Voor bijeenkomst mogelijk relevante relaties met bedrijven	Bedrijfsnamen
• Sponsoring of onderzoeksgeld • Honorarium of andere (financiële) vergoeding • Aandeelhouder • Andere relatie, namelijk …	• Baxter • • •

Dutch nOcturnal and hoME dialysis Study To Improve Clinical Outcomes

DOMESTICO: Hoe het allemaal begon…..

UMC Utrecht

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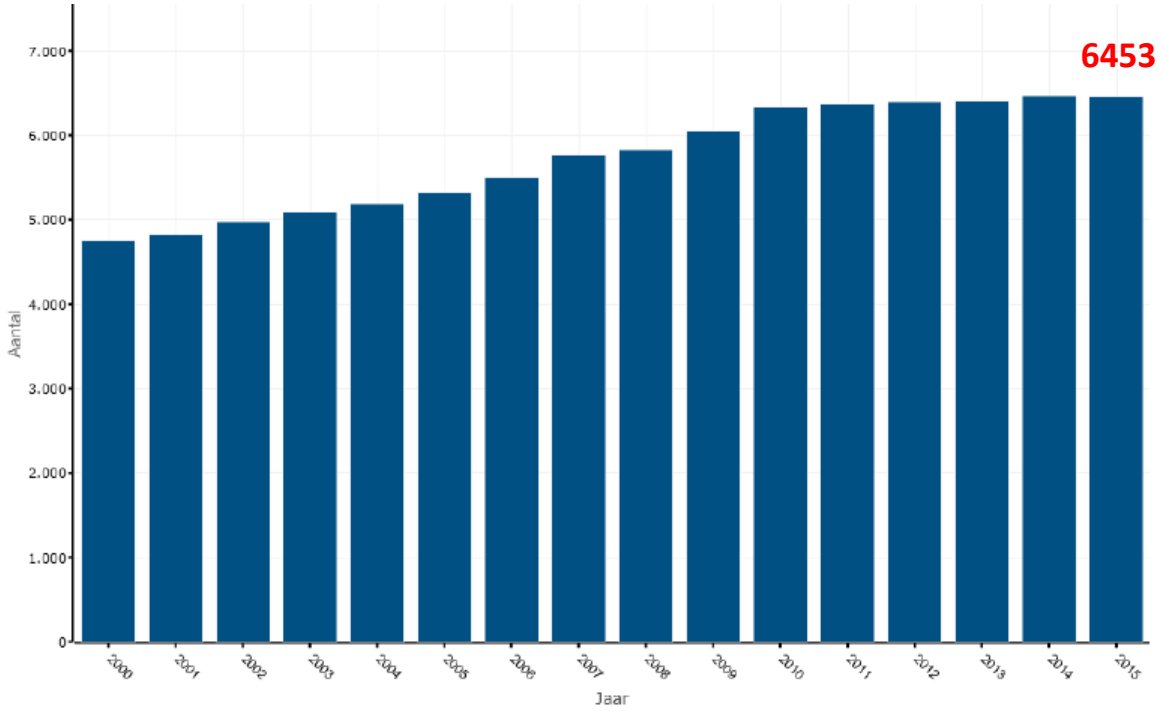
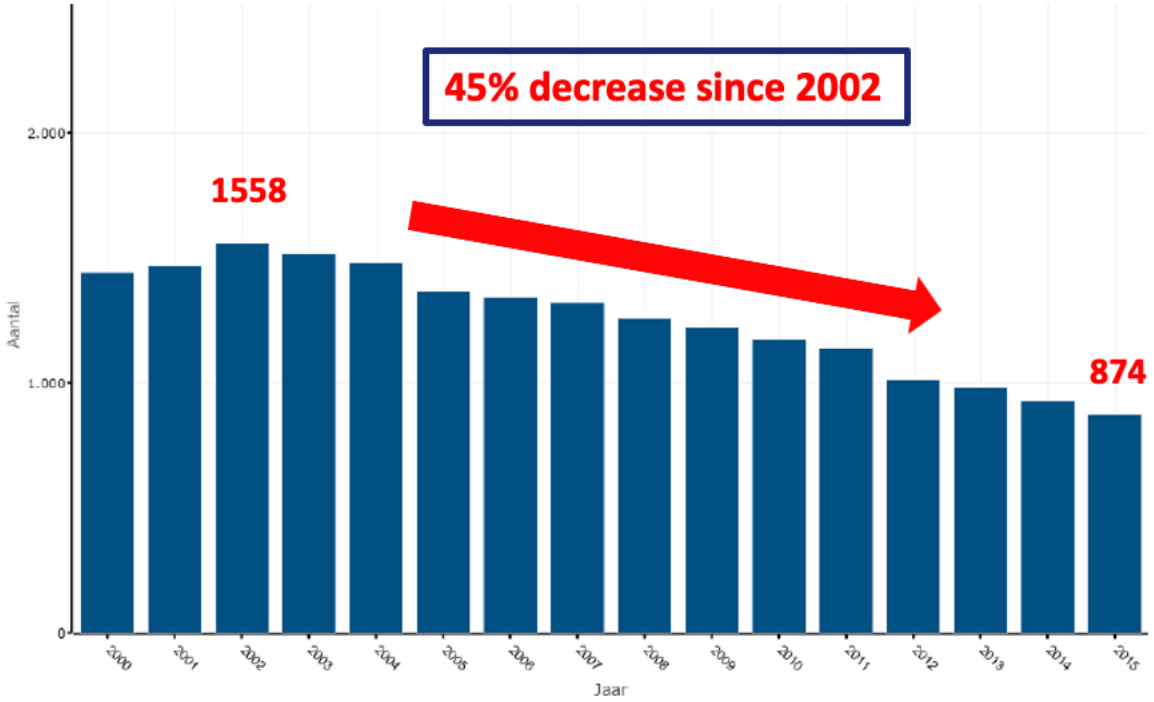
Aantal dialyse patiënten (2000-2015)



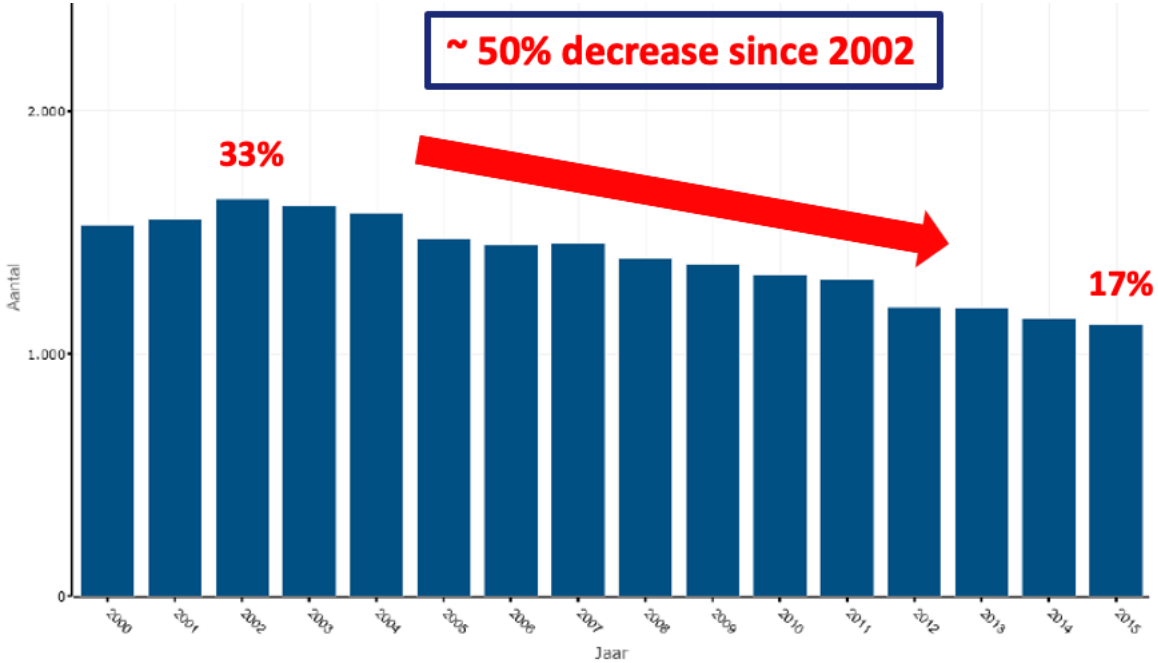
Nefrodata

Aantal PD patiënten (2000-2015)



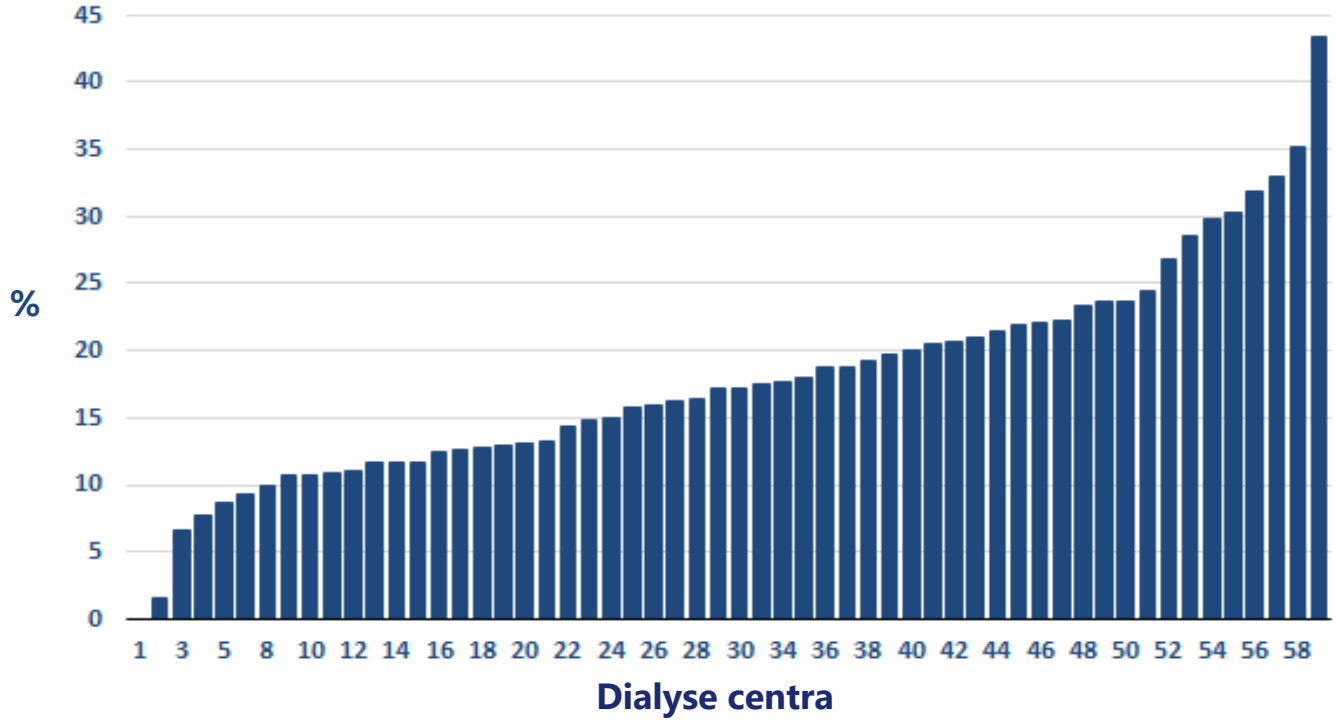
Nefrodata

Aantal thuisdialyse patiënten (2000-2015)



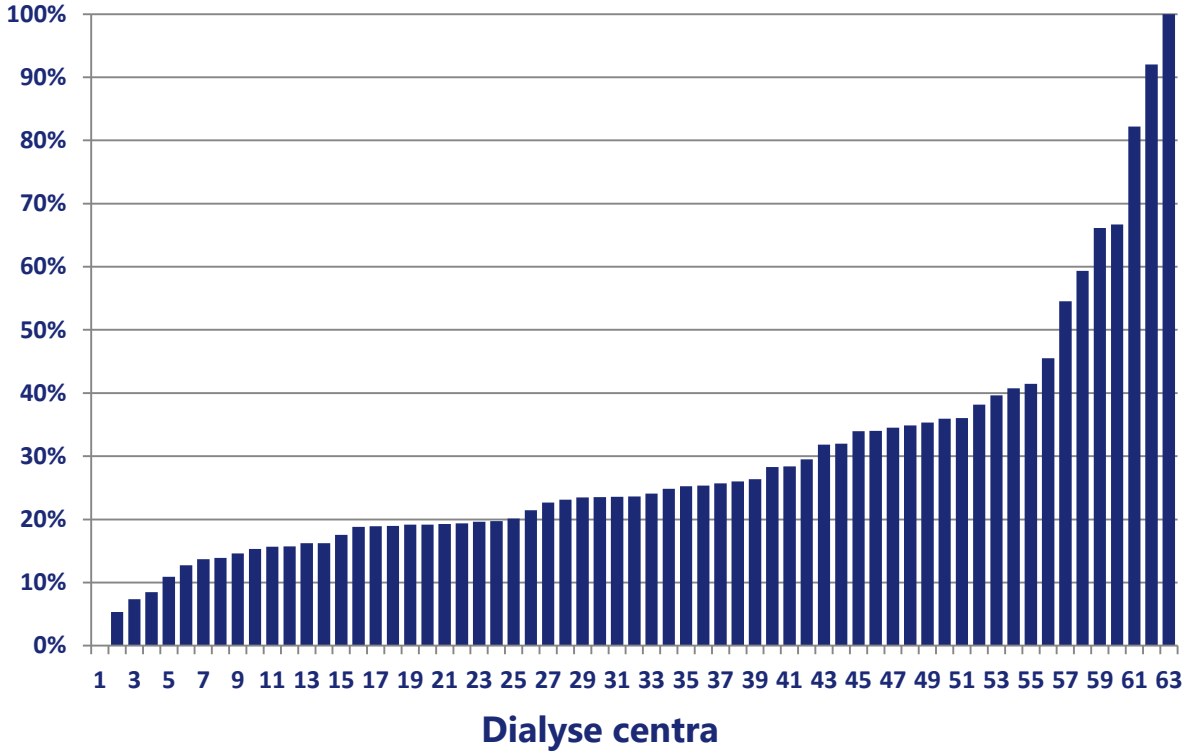
Nefrodata

Proportie PD patiënten per centrum (2015)



Nefrodata

PD Techniekfalen per centrum (2012-2014)



Nefrodata


@
DOMESTICO

Dutch nOcturnal and hoME dialysis Study To Improve Clinical Outcomes

DOMESTICO

Wanneer is DOMESTICO prospectief van start gegaan?

A. September 2017
B. Oktober 2017
C. November 2017
D. December 2017

Dutch nOcturnal and hoME dialysis Study To Improve Clinical Outcomes

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DOMESTICO
PROMs

DOMESTICO
Kosten

DOMESTICO
Klinische uitkomsten

DOMESTICO
Best Practices en SDM

Retrospectief

Best Practices en SDM

2012-2017	2018	2019	2020	2021

NIERSTICHTING
Leven gaat voor

Retrospectief

DOMESTICO
PROMs

DOMESTICO
Kosten

DOMESTICO
Klinische uitkomsten

DOMESTICO
Best Practices en SDM

ZonMw

Dirinco
Always innovating

VIFOR PHARMA

eurocept

Baxter

NOVARTIS

BAYER

AstraZeneca

FRESENIUS MEDICAL CARE

cablon medical

menzis

Federatie Medisch Specialisten

Best Practices en SDM

CZ

Zilveren Kruis

2012-2017	2018	2019	2020	2021

DOMESTICO retrospectief

- Vraag:
  - *Oorzaken van techniekfalen bij thuisdialyse?*
  - *Modificeerbare factoren?*
  - *Klinische uitkomsten?*
- Dossieronderzoek
- 1200 thuisdialyse v.s. 600 CHD pt
- Start dialyse tussen 1-1-2012 t/m 1-1-2017

→ 41 deelnemende centra

→ 3 publicaties

Original Article

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Peritoneal Dialysis International
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Technique failure in peritoneal dialysis: Modifiable causes and patient-specific risk factors

Anna A Bonenkamp[1], Anita van Eck van der Sluijs[2], Friedo W Dekker[3], Dirk G Struijk[4], Carola WH de Fijter[5], Yolande M Vermeeren[6], Frans J van Ittersum[1], Marianne C Verhaar[2], Brigit C van Jaarsveld[1,7], and Alferso C Abrahams[2] on behalf of the DOMESTICO study group.

PD techniekfalen

- Primaire eindpunt ‘PD techniekfalen’
  - transfer naar CHD voor ≥30 dgn, overlijden op PD of <30 dgn na transfer naar CHD
  - vroeg (<6 mnd na start PD) vs. laat (>6 mnd na start PD)

- Secundaire eindpunten
  - death-censored techniekfalen
  - overlijden
  - permanent techniekfalen (180 dgn)

PD techniekfalen

695 patiënten, 33 centra

Table 1. Baseline characteristics of 695 patients treated with peritoneal dialysis.[a]

	All patients $n = 695$	Patients with technique failure $n = 318$	Patients without technique failure $n = 377$	p-Value
Age (year), mean ± SD	62.9 ± 15.1	64.8 ± 14.8	61.4 ± 15.1	0.003
Sex (male), *n* (%)	447 (64)	210 (66)	237 (63)	NS
Ethnic background, *n* (%)				NS
Caucasian	422 (61)	191 (60)	231 (61)	
Moroccan/Turkish	22 (3)	11 (4)	11 (3)	
Asian	39 (6)	15 (5)	24 (6)	
Black	23 (3)	9 (3)	14 (4)	
Other/unknown	189 (27)	92 (29)	97 (26)	
Primary kidney disease, *n* (%)				NS
Glomerulonephritis	81 (12)	32 (10)	49 (13)	
Polycystic kidney disease	37 (5)	11 (4)	26 (7)	
Renovascular kidney disease	210 (30)	112 (35)	98 (26)	
Diabetes mellitus	123 (18)	58 (18)	65 (17)	
Other	183 (26)	84 (27)	99 (26)	
Unknown	61 (9)	21 (7)	40 (11)	
Employment status, *n* (%)	167 (28)	61 (22)	106 (32)	0.006
Current smoker, *n* (%)	111 (16)	52 (17)	59 (16)	NS
Charlson comorbidity index, *n* (%)	168 (32)	58 (25)	110 (38)	0.001
2 (low)[b]	212 (41)	95 (41)	117 (40)	
3–4 (intermediate)	139 (27)	77 (33)	62 (21)	
≥5 (severe)				
BMI (kg/m^2), mean ± SD	26.4 ± 5.0	26.9 ± 5.1	26.1 ± 4.9	0.05
BMI, *n* (%)				NS
<25 kg/m^2	239 (46)	98 (42)	141 (49)	
25–30 kg/m^2	177 (34)	85 (36)	92 (32)	
≥30 kg/m^2	107 (20)	51 (22)	56 (19)	
Diabetes mellitus, *n* (%)	164 (32)	81 (35)	83 (29)	NS
Ischemic heart disease, *n* (%)	146 (28)	80 (35)	66 (23)	0.002
Heart failure, *n* (%)	69 (13)	38 (17)	31 (11)	NS
Vascular disease, *n* (%)	130 (23)	65 (26)	65 (21)	NS
History of dialysis at dialysis initiation, *n* (%)	103 (15)	39 (12)	64 (17)	NS
Dialysis vintage (months), median [IQR]	12 [1–36]	12 [4–37]	11 [1–33]	NS
History of kidney transplant at dialysis initiation, n (%)	73 (11)	29 (9)	44 (12)	NS
Kidney transplant (months), median [IQR]	120 [64–171]	99 [64–171]	135 [63–173]	NS
APD, *n* (%)	350 (50)	146 (46)	204 (54)	0.03

BMI: body mass index; APD: automated peritoneal dialysis; SD: standard deviation; IQR: interquartile range.
[a]Groups are defined according to the 30-day definition of technique failure.
[b]Kidney failure alone represents a Charlson Comorbidity Index of 2 points.

PD techniekfalen

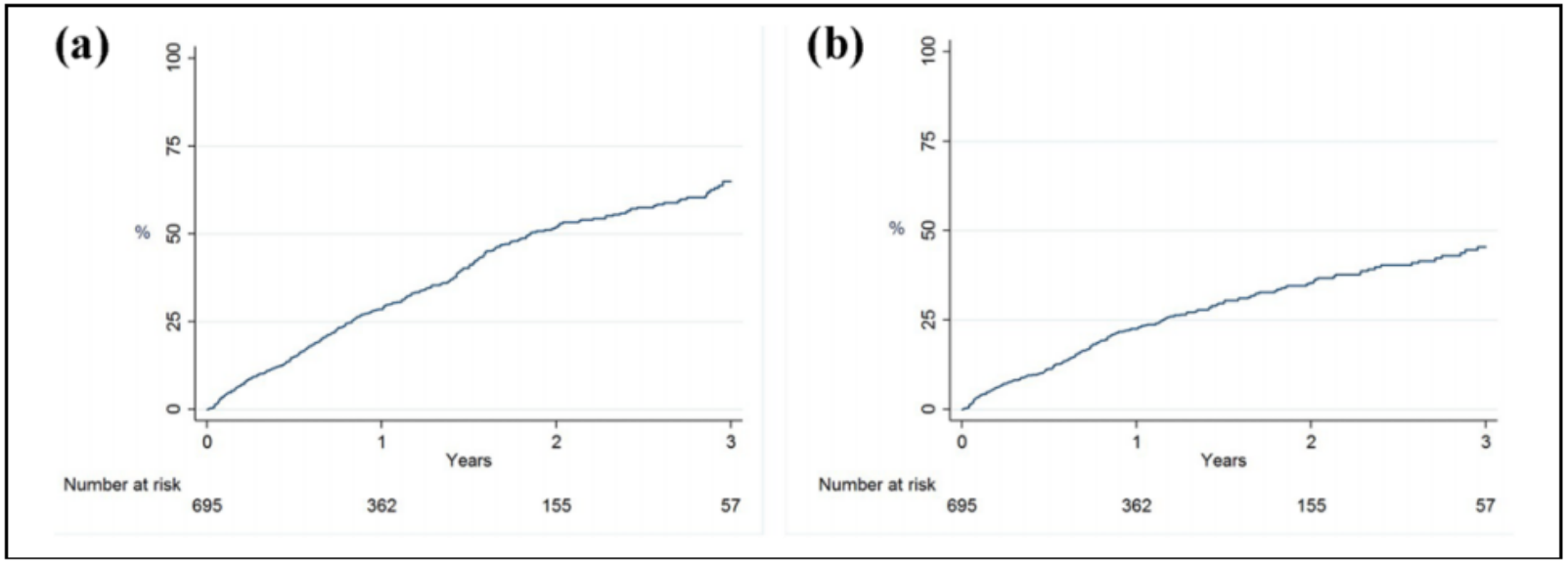

Figure 2. Technique failure, as a composite outcome (with transfer to CHD or death) (a) and as death-censored technique failure (b). Technique failure was defined as a transfer to CHD for ≥30 days, death on PD or death within 30 days after transfer to CHD. First day of receiving CHD was the date assigned as technique failure. PD: peritoneal dialysis; CHD: in-centre haemodialysis.

Retrospectief	Prospectief	BP&SDM	Mantelzorg

PD techniekfalen

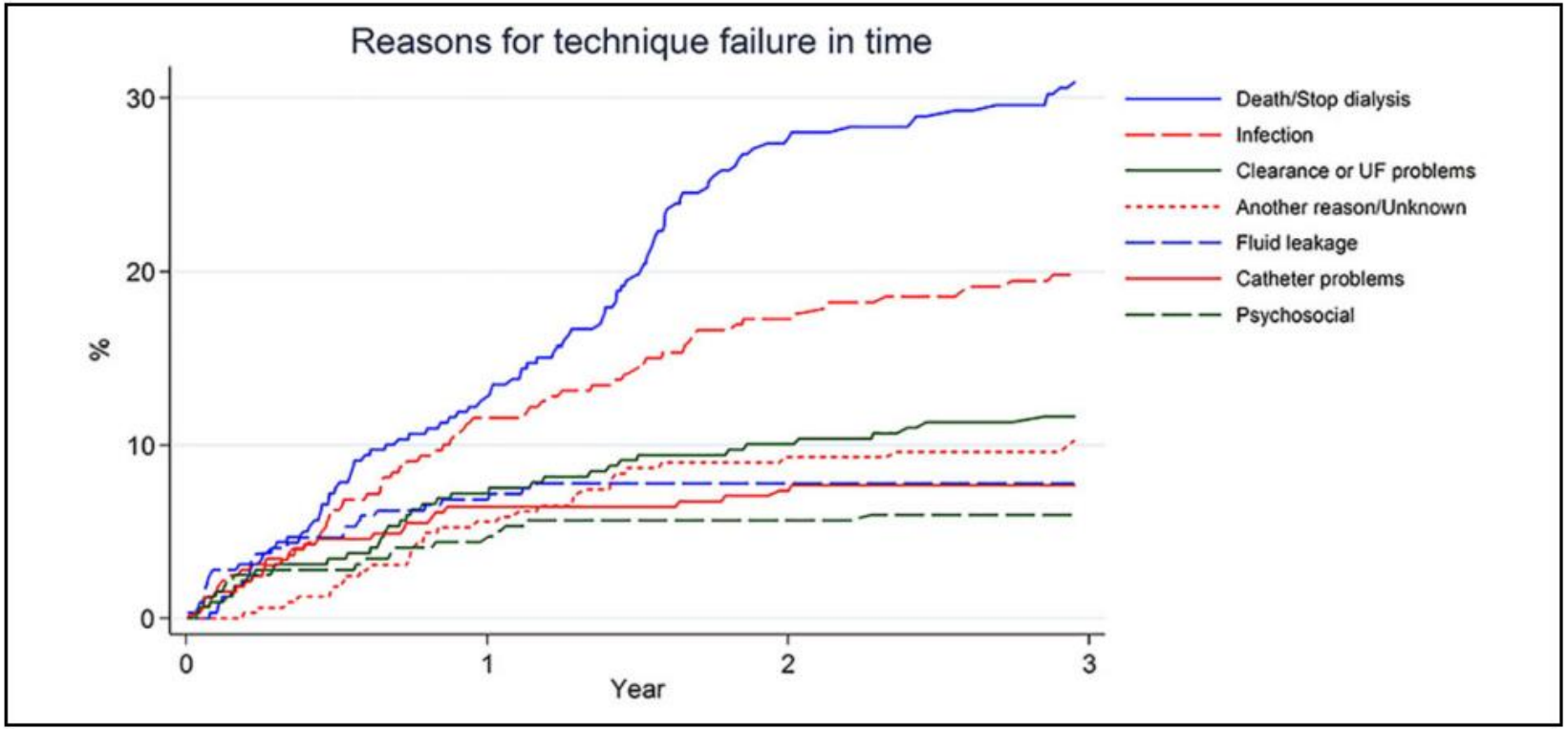

Figure 3. Cumulative incidence of different causes for technique failure shows the occurrence of different causes for technique failure over time in a population of patients with technique failure (n = 318, 100%). UF: ultrafiltration.

PD techniekfalen

Table 2. Risk factors associated with technique failure in a Cox regression model.[a]

Risk factors	Crude HR (95% CI)	*p*-Value	Adjusted model 1 HR (95% CI)	*p*-Value	Adjusted model 2 HR (95% CI)	*p*-Value
Male sex	1.15 (0.91–1.45)	0.24				
Age (10-year)	1.05 (0.97–1.13)	0.25				
Employed	0.80 (0.60–1.07)	0.13				
CCI						
Low	Reference					
Intermediate	1.41 (1.02–1.96)	0.04				
Severe	1.81 (1.29–2.55)	0.001				
PD volume						
<15 patients	Reference					
15–25 patients	1.05 (0.68 –1.63)	0.83				
>25 patients	0.81 (0.53–1.24)	0.33				
BMI						
<25 kg/m^2	Reference		Reference			
25–30 kg/m^2	1.21 (0.91–1.62)	0.20	1.17 (0.87–1.58)	0.31		
≥30 kg/m^2	1.21 (0.86–1.69)	0.28	1.23 (0.88–1.71)	0.22		
APD (vs CAPD)	0.66 (0.53–0.83)	<0.001	0.67 (0.54–0.84)	<0.001	0.66 (0.53–0.83)	<0.001

HR: hazard ratio; CI: confidence interval; BMI: body mass index; APD: automated peritoneal dialysis; CAPD: continuous ambulatory peritoneal dialysis; CCI: Charlson Comorbidity index.

[a]Model 1 is adjusted for age and sex. Model 2 is adjusted for age, sex, employment status, BMI, CCI and centre PD volume. In this cox regression model both preselected potentially modifiable risk factors, BMI and PD modality and all determinants used for adjustments are shown.

Differences in hospitalisation between peritoneal dialysis and haemodialysis patients

Anita van Eck van der Sluijs[1] | Anna A. Bonenkamp[2] | Vera A. van Wallene[1] | Tiny Hoekstra[2] | Birgit I. Lissenberg-Witte[3] | Friedo W. Dekker[4] | Frans J. van Ittersum[2] | Marianne C. Verhaar[1] | Brigit C. van Jaarsveld[2,5] | Alferso C. Abrahams[1] | the DOMESTICO study group

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Eur J Clin Invest. 2022;52:e13758.

Retrospectief	Prospectief	BP&SDM	Mantelzorg

Hospitalisatie

- Primaire eindpunt ‘Hospitalisation rate’
  - aantal hospitalisaties per patient-jaar
- Secundaire eindpunten
  - risico voor 1^{e} hospitalisatie
  - totale aantal hospitalisaties per patient
  - aantal hospitalisatie dagen per patient-jaar
  - oorzaken

Hospitalisatie

695 patiënten, 31 centra

TABLE 1 Baseline characteristics according to dialysis modality at 3 months

Variable	Full sample $n = 695$	PD $n = 252$	HD $n = 443$
Age (yr), mean ± SD	63.0 ± 15.3	63.1 ± 14.9	62.9 ± 15.6
Sex (male), *n* (%)	418 (60)	160 (64)	258 (58)
Ethnic background, *n* (%)			
Caucasian	395 (57)	149 (59)	246 (56)
Other	123 (18)	30 (12)	93 (21)
Unknown	177 (25)	73 (29)	104 (23)
Primary kidney disease, *n* (%)			
Glomerulonephritis/pyelonephritis	141 (20)	39 (16)	102 (23)
Cystic kidney disease	38 (6)	19 (8)	19 (4)
Renovascular kidney disease	193 (28)	71 (28)	122 (28)
Diabetes mellitus	119 (17)	49 (19)	70 (16)
Other/unknown	204 (29)	74 (29)	130 (29)
BMI (kg/m^2), mean ± SD	26.8 ± 5.5	26.6 ± 4.7	26.9 ± 6.0
Smoking, *n* (%)			
Yes	117 (17)	42 (17)	75 (17)
Quit	172 (25)	67 (27)	105 (24)
Unknown	103 (15)	36 (14)	67 (15)
CCI score, *n* (%)[a]			
2	208 (30)	84 (33)	124 (28)
3–4	281 (41)	97 (39)	184 (42)
≥ 5	204 (29)	71 (28)	133 (30)
Davies score, *n* (%)			
0	182 (26)	77 (31)	105 (24)
1–2	370 (53)	125 (50)	245 (56)
≥ 3	141 (20)	50 (20)	91 (21)
KRT vintage (months), median [IQR][b]	150 [64–212]	138 [44–181]	154 [69–230]
Dialysis vintage (months), median [IQR][c]	35 [15–58]	16 [9–41]	39 [19–64]
Previous transplant, *n* (%)	138 (20)	26 (10)	112 (25)
Residual GFR (ml/min), median [IQR]	7.8 [4.6–11.6]	9.5 [6.7–12.9]	6.6 [3.3–10.4]
Residual diuresis (ml/day), mean ± SD	1459 ± 841	1708 ± 743	1317 ± 862
Acute start of dialysis, *n* (%)	98 (14)	11 (4)	87 (20)

Retrospectief | **Prospectief** | **BP&SDM** | **Mantelzorg**

Hospitalisatie

TABLE 2 Comparison of hospitalisation rate (hospitalisations per patient-year) and risk for first hospitalisation.

Dialysis modality	Crude HR (95% CI)	Adjusted* HR (95% CI)	Adjusted** HR (95% CI)
Hospitalisations per patient-year			
PD vs HD	1.1 (1.03–1.3)	1.1 (1.02–1.3)	1.1 (1.02–1.3)
Risk for first hospitalisation during first year after dialysis initiation			
PD vs HD	1.3 (1.1–1.6)	1.3 (1.1–1.6)	1.3 (1.1–1.6)
Risk for first hospitalisation ≥1 year after dialysis initiation			
PD vs HD	1.8 (1.4–2.5)	1.8 (1.4–2.5)	1.9 (1.4–2.5)

Note: The hospitalisation rate was calculated with a multi-state model with recurrent events, which attributed every hospitalisation to the dialysis modality the patient performed at the time of admission.

The risk for first hospitalisation was analysed with a Cox regression model with dialysis modality as time-varying covariate.

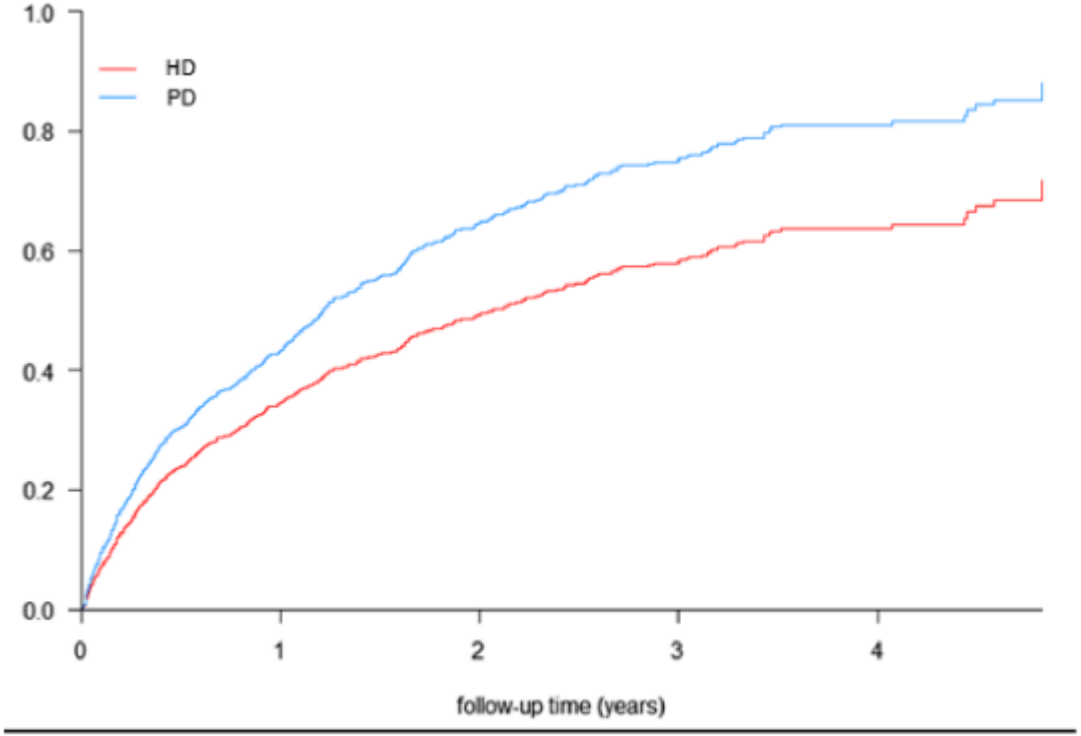
TABLE 3 Comparison of number of hospitalisations and number of hospital days per patient-year.

Dialysis modality	Crude IRR (95% CI)	Adjusted* IRR (95% CI)	Adjusted** IRR (95% CI)
Number of hospitalisations			
PD/HD	1.3 (1.1–1.6)	1.7 (1.3–2.3)	1.7 (1.2–2.3)
Number of hospital days per patient-year			
PD/HD	1.6 (1.2–2.1)	1.6 (1.2–2.1)	1.5 (1.2–2.1)

Abbreviations: HD, Haemodialysis; IRR, Incidence rate ratio of PD relative to HD; PD, Peritoneal dialysis.

*Adjusted for age and sex

**Adjusted for age, sex, Charlson Comorbidity Index, dialysis vintage and acute start of dialysis



PD= peritoneal dialysis; HD= haemodialysis.
Estimated cumulative incidence curves for first hospitalisation for PD and HD patients derived from a multi-state Cox regression model. Model is adjusted for age, sex, Charlson Comorbidity Index, dialysis vintage, and acute start of dialysis.

Hospitalisatie

TABLE 4 Causes of hospitalisations.

Causes	PD $n = 521$	HD $n = 959$
Access-related[a]	69 (13)	317 (33)
Peritonitis	117 (23)	N/A
Fluid overload	14 (3)	22 (2)
Cardiac disease[b]	57 (11)	87 (9)
Vascular disease[c]	28 (5)	50 (5)
Infection[d]	79 (15)	170 (18)
Gastrointestinal disease	46 (9)	94 (10)
Malignancy	9 (2)	25 (3)
Transplantation	13 (2)	25 (2)
Other/unknown	89 (17)	169 (18)

ORIGINAL ARTICLE

NEPHROLOGY APSN WILEY

Comorbidity is not associated with dialysis modality choice in patients with end-stage kidney disease

Anna A. Bonenkamp[1] | Sanne Vonk[2] | Alferso C. Abrahams[2] | Yolande M. Vermeeren[3] | Anita van Eck van der Sluijs[2] | Tiny Hoekstra[1] | Frans J. van Ittersum[1] | Brigit C. van Jaarsveld[1] | DOMESTICO study group

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Nephrology. 2022;27:510–518.

Retrospectief	Prospectief	BP&SDM	Mantelzorg

Comorbiditeit

- Primaire doel:
  - associatie tussen comorbiditeit en dialyse modaliteit onderzoeken
- Secundaire doelen:
  - associatie tussen dialyse modaliteit en
    - Diabetes mellitus
    - Ischemische hartziekte
    - Hartfalen
    - Cerebrovasculaire ziekte
    - Maligniteit
    - Chronische longziekte

Comorbiditeit

1358 patiënten, 35 centra

Retrospectief

TABLE 1 Characteristics of the 1358 included dialysis patients, divided by dialysis modality

	All patients (n = 1358)	Home dialysis (n = 628)	In-centre haemodialysis (n = 730)	p-value
Male sex, n (%)	832 (61)	390 (62)	442 (61)	.58
Age (year), mean ± SD	62.4 ± 15.7	61.6 ± 15.6	63.1 ± 15.8	.08
Body mass index (kg/m^2), mean ± SD	26.8 ± 5.6	26.4 ± 5.1	27.2 ± 6.0	.01
Ethnic background, n (%)				<.001
Caucasian	805 (59)	403 (64)	402 (55)	
Moroccan/Turkish	73 (5)	13 (2)	60 (8)	
Asian	71 (5)	35 (6)	36 (5)	
Afro-American	60 (4)	21 (3)	39 (5)	
Unknown	330 (24)	146 (23)	184 (25)	
ERA-EDTA code, n (%)				.62
Glomerulonephritis/pyelonephritis	261 (19)	125 (20)	136 (19)	
Cystic kidney disease	78 (6)	39 (6)	39 (5)	
Renovascular kidney disease	355 (26)	164 (26)	191 (26)	
Diabetes mellitus	243 (18)	102 (16)	141 (19)	
Other/unknown	421 (31)	198 (32)	223 (31)	
Previous dialysis, n (%)	276 (20)	121 (19)	155 (21)	.38
Dialysis vintage (mo), median (IQR)[a]	29.4 [11.0–57.7]	17.7 [2.2–45.4]	38.4 [15.4–62.8]	<.001
Previous renal transplant, n (%)	241 (18)	92 (15)	149 (20)	.007
Charlson comorbidity index, n (%)				.16
2 (no comorbidity)	409 (30)	202 (32)	207 (28)	
3–4 (intermediate comorbidity score)	553 (41)	257 (41)	296 (41)	
≥5 (high comorbidity score)	396 (29)	169 (27)	227 (31)	
Davies comorbidity score, n (%)				.43
0 (no comorbidity)	398 (29)	194 (31)	204 (28)	
1–2 (intermediate risk)	722 (53)	330 (53)	392 (54)	
≥3 (high comorbidity score)	238 (18)	104 (17)	134 (18)	
Diabetes mellitus, n (%)	465 (34)	193 (31)	272 (37)	.012
Ischaemic heart disease, n (%)	378 (28)	182 (29)	196 (27)	.40
Heart failure, n (%)	149 (11)	83 (13)	66 (9)	.018
Cerebrovascular disease, n (%)	187 (14)	84 (13)	103 (14)	.75
Any malignancy, n (%)	192 (14)	81 (13)	111 (15)	.24
Chronic lung disease, n (%)	159 (12)	67 (11)	92 (13)	.27

[a]Dialysis vintage presented for patients with previous dialysis only.

Comorbiditeit

TABLE 3 Association of comorbidity and treatment with home dialysis, compared with in-centre haemodialysis

	Logistic mixed model regression analysis[a]					
	Odds ratio [95% CI] crude	*p*-value	Odds ratio [95% CI] adjusted[b]	*p*-value	Odds ratio [95% CI] adjusted[c]	*p*-value
Charlson comorbidity index						
CCI 2	REF		REF		REF	
CCI 3–4	0.97 [0.73–1.28]	.82	1.05 [0.78–1.41]	.73	1.10 [0.82–1.49]	.53
CCI ≥5	0.74 [0.54–1.00]	.05	0.84 [0.61–1.17]	.30	0.88 [0.63–1.23]	.44
At least 1 comorbidity	0.86 [0.67–1.12]	.26	0.97 [0.74–1.27]	.81	1.01 [0.77–1.33]	.93
Diabetes mellitus[d]	0.75 [0.59–0.97]	.03	0.78 [0.61–1.01]	.06	0.83 [0.64–1.08]	.17
Ischaemic heart disease	1.08 [0.83–1.40]	.57	1.17 [0.89–1.55]	.26	1.23 [0.93–1.63]	.15
Heart failure	1.47 [1.01–2.14]	.05	1.54 [1.05–2.25]	.03	1.60 [1.09–2.37]	.02
Cerebrovascular disease	0.79 [0.57–1.11]	.18	0.83 [0.59–1.17]	.28	0.81 [0.57–1.15]	.24
Any malignancy	0.91 [0.65–1.28]	.58	0.92 [0.65–1.30]	.65	0.89 [0.63–1.26]	.50
Chronic lung disease	0.83 [0.58–1.21]	.34	0.88 [0.61–1.29]	.52	0.88 [0.60–1.29]	.50

Abbreviations: BMI, body mass index; CCI, Charlson comorbidity index.

[a]Logistic mixed model regression analysis with dialysis centre as random intercept, with individual patients as first level.

[b]Adjusted for age, sex, and BMI.

[c]Adjusted for age, sex, BMI, ethnic background, and dialysis vintage.

[d]Adjusted for age, sex, ethnic background, and dialysis vintage.

Comorbiditeit

TABLE 4 Interaction of BMI in the association between CCI and treatment with home dialysis, compared with in-centre haemodialysis

	Logistic mixed model regression analysis[a]			
	Odds ratio [95% CI] crude	*p*-value	Odds ratio [95% CI] adjusted[b]	*p*-value
Patients with BMI <25 kg/m^2 (*N* = 493)[c]				
Charlson comorbidity index				
CCI 2	REF		REF	
CCI 3–4	1.37 [0.89–2.11]	0.15	1.59 [1.01–2.49]	.04
CCI ≥ 5	1.03 [0.62–1.69]	0.92	1.22 [0.72–2.07]	.46
Overweight patients (BMI 25–30 kg/m^2) (*N* = 379)[c]				
Charlson comorbidity index				
CCI 2	REF		REF	
CCI 3–4	1.00 [0.61–1.64]	0.99	1.10 [0.66–1.83]	.72
CCI ≥5	0.71 [0.41–1.24]	0.22	0.76 [0.43–1.35]	.36
Obese patients (BMI ≥30 kg/m^2) (*N* = 257)[c]				
Charlson comorbidity index				
CCI 2	REF		REF	
CCI 3–4	0.40 [0.19–0.86]	0.02	0.40 [0.18–0.86]	.02
CCI ≥ 5	0.42 [0.20–0.88]	0.02	0.43 [0.20–0.93]	.03

Note: BMI was divided according to the WHO classification: BMI <25 kg/m^2, BMI 25–30 kg/m^2 (overweight), and BMI ≥30 kg/m^2 (obese).

Abbreviations: BMI, body mass index; CCI, Charlson comorbidity index.

[a]Logistic mixed model analysis with dialysis centre as random intercept, with individual patients as first level.

[b]Adjusted for age, sex, ethnic background, and dialysis vintage.

[c]A total of 1358 patients were analysed: for 229 patients imputed data for BMI were used.

DOMESTICO
PROMs

DOMESTICO
Kosten

DOMESTICO
Klinische uitkomsten

DOMESTICO
Best Practices en SDM

Retrospectief

Best Practices en SDM

2012-2017	2018	2019	2020	2021

DOMESTICO prospectief

- Vraag:

Leidt behandeling met thuisdialyse tot een betere kwaliteit van leven, gelijke klinische uitkomsten en lagere kosten in vergelijking tot CHD?

- Multicenter cohort
- 800 thuisdialyse pt (600 PD, 200 THD) en 800 CHD pt
- 12-48 mnd follow-up
- Verwachte einddatum 1-6-2022

→ 58 deelnemende centra (NL & België)

→ 4 publicaties

Dutch nOcturnal and hoME dialysis Study To Improve Clinical Outcomes

Hoeveel inclusies zijn er op dit moment in DOMESTICO prospectief?

A. ~1000
B. ~1500
C. ~2000
D. ~2500

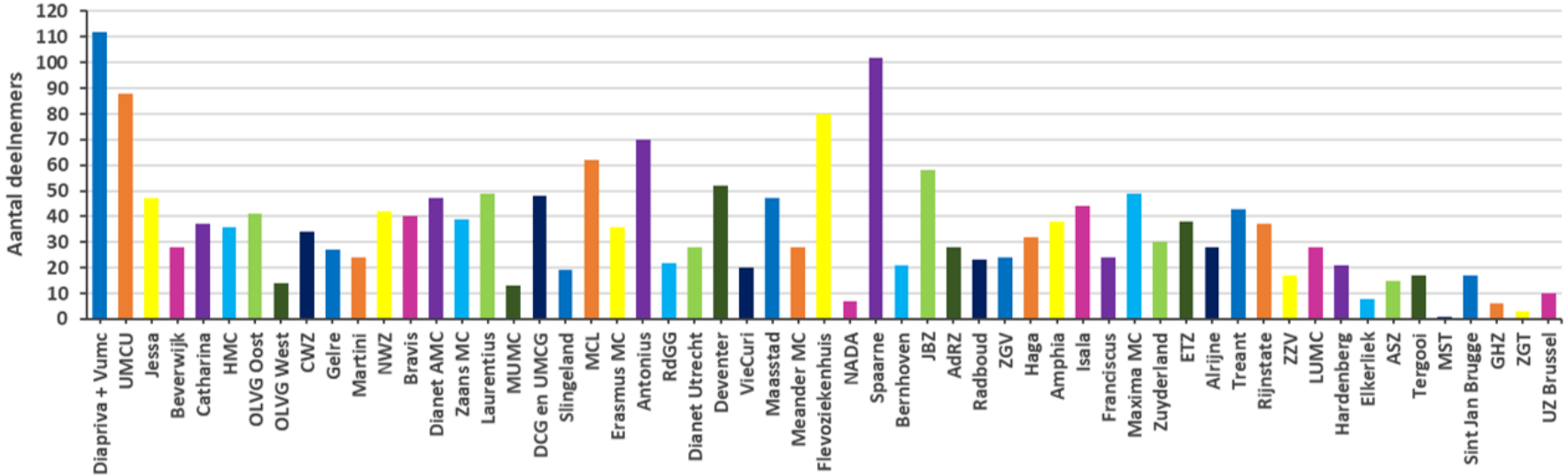
Dutch nOcturnal and hoME dialysis Study To Improve Clinical Outcomes

Hoeveel inclusies zijn er op dit moment in DOMESTICO prospectief?

A. ~1000
B. ~1500
C. ~2000
D. ~2500

DOMESTICO prospectief
Huidige status: > 2000 inclusies

55 Nederlandse centra
3 Belgische centra



Retrospectief	**Prospectief**	BP&SDM	Mantelzorg

Eck van der Sluijs *et al. BMC Nephrology* (2019) 20:361
https://doi.org/10.1186/s12882-019-1526-4

BMC Nephrology

STUDY PROTOCOL Open Access

Dutch nOcturnal and hoME dialysis Study To Improve Clinical Outcomes (DOMESTICO): rationale and design

A. van Eck van der Sluijs[1†], A. A. Bonenkamp[2†], F. W. Dekker[3], A. C. Abrahams[1], B. C. van Jaarsveld[2,4*] and on behalf of the DOMESTICO study group

Retrospectief	**Prospectief**	BP&SDM	Mantelzorg

Original Research

Kidney Medicine

Health-Related Quality of Life in Home Dialysis Patients Compared to In-Center Hemodialysis Patients: A Systematic Review and Meta-analysis

Anna A. Bonenkamp, Anita van Eck van der Sluijs,* Tiny Hoekstra, Marianne C. Verhaar, Frans J. van Ittersum, Alferso C. Abrahams, and Brigit C. van Jaarsveld*

Kidney Med Vol 2 | Iss 2 | March/April 2020

How does health-related quality of life in home dialysis patients compare to in-center hemodialysis patients?

Kidney Medicine

Systematic review & meta-analysis

Home dialysis vs In-center dialysis

Health-related quality of life (HRQoL)

46 articles

- 42 Cross-sectional
- 4 Cohort

41 study populations

- 38 Peritoneal dialysis
- 2 Home hemodialysis
- 1 Both

Meta-analysis

N=4158 N=7854

Pooled Analysis

Better physical HRQoL in home dialysis patients

Subgroup Analysis

Latin America

Better physical HRQoL with in-center dialysis

Western Europe

Better physical HRQoL with home dialysis

Conclusions: Although pooled data showed a marginally better physical HRQoL for home dialysis patients, the quality of design of the included studies was poor. Large prospective studies with adequate adjustments for confounders are necessary to establish whether home dialysis results in better HRQoL.

Reference: Bonenkamp AA, van Eck van der Sluijs A, Hoekstra T, Verhaar MC, van Ittersum FJ, Abrahams AC, van Jaarsveld BC. Health-Related Quality of Life in Home Dialysis Patients Compared to In-Center Hemodialysis Patients: A Systematic Review and Meta-analysis. Kidney Medicine, 2020.

Visual abstract by Pablo Galindo, MD

Journal of Nephrology
https://doi.org/10.1007/s40620-021-01005-1

ORIGINAL ARTICLE

Check for updates

The Impact of COVID-19 on the mental health of dialysis patients

Anna A. Bonenkamp[1] · Theresia A. Druiventak[2] · Anita van Eck van der Sluijs[2] · Frans J. van Ittersum[1] · Brigit C. van Jaarsveld[1,3] · Alferso C. Abrahams[2] on behalf of the DOMESTICO study group

Received: 18 December 2020 / Accepted: 17 February 2021

COVID-19

Methods

Data from nationwide cohort study

Quality of life questionnaires during pandemic and 3-6 months prior

February 27th and July 1st 2020

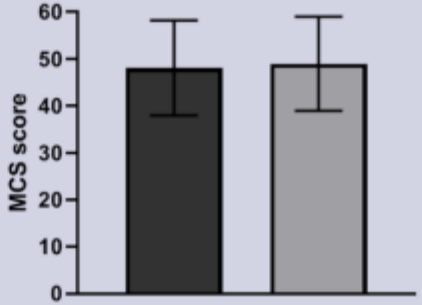
Cohort

n = 177

Age 64.9 ± 11.5

75% in-center haemodialysis

Results



Adjusted mean MCS score 0.93 point (95% CI -0.57 – 2.42) higher during the COVID-19 pandemic

No difference in the presence of mental-health related symptoms during the COVID-19 pandemic

AJN
American Journal
of Nephrology

**Patient-Oriented, Translational Research:
Research Article**

Am J Nephrol
DOI: 10.1159/000518454

Received: April 26, 2021
Accepted: June 24, 2021
Published online: September 10, 2021

Impact of Polypharmacy on Health-Related Quality of Life in Dialysis Patients

Julia M.T. Colombijn[a] Anna A. Bonenkamp[a] Anita van Eck van der Sluijs[b]
Joost A. Bijlsma[a, c] Arnold H. Boonstra[d] Akin Özyilmaz[e, f] Alferso C. Abrahams[b]
Brigit C. van Jaarsveld[a, g] on behalf of the DOMESTICO study group

[a]Department of Nephrology, Amsterdam UMC, Research Institute Amsterdam Cardiovascular Sciences, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands; [b]Department of Nephrology and Hypertension, University Medical Centre Utrecht, Utrecht, The Netherlands; [c]Dianet Dialysis Centre, Amsterdam, The Netherlands; [d]Department of Nephrology, Flevoziekenhuis, Almere, The Netherlands; [e]Dialysis Centre Groningen, Groningen, The Netherlands; [f]Division of Nephrology, Department of Internal Medicine, University Medical Center Groningen, Groningen, The Netherlands; [g]Diapriva Dialysis Centre, Amsterdam, The Netherlands

Retrospectief	**Prospectief**	BP&SDM	Mantelzorg

Polyfarmacie

- Doel:
  - associatie tussen soorten medicatie en kwaliteit van leven
- 3 mnd na start dialyse:
  - medicatie: aantal gelijktijdig voorgeschreven soorten medicatie
  - kwaliteit van leven
- Polyfarmacie: gelijktijdig voorschrijven van ≥5 soorten medicatie

Polyfarmacie

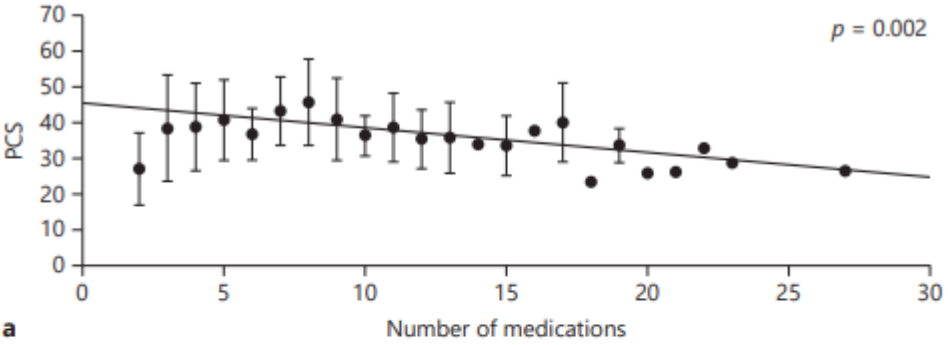
162 patiënten, 7 centra

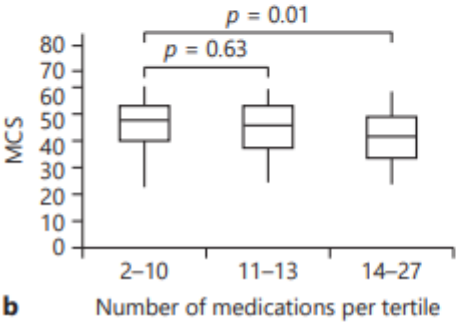
Retrospectief

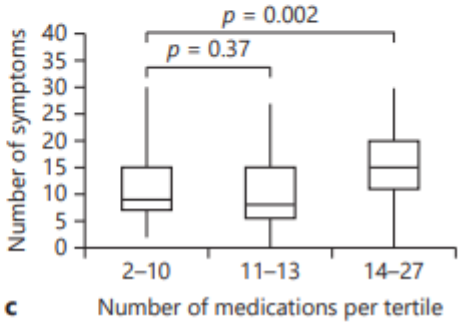
Table 1. Patient characteristics for all patients and per medication tertile

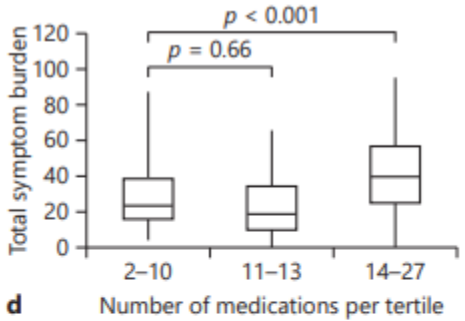
	All patients (n = 162)	2–10 medications (n = 59)	11–13 medications (n = 42)	14–27 medications (n = 61)
Demographic data				
Age, years	58±17	55±19	62±15	59±14
Sex (female)	56 (35)	22 (37)	12 (29)	22 (36)
Medical history				
Cause of kidney failure[a]				
Glomerular/tubular nephropathy	38 (24)	12 (20)	10 (24)	16 (26)
Cystic kidney disease	15 (9)	10 (17)	2 (5)	3 (5)
Renovascular nephropathy	44 (27)	15 (25)	15 (36)	14 (23)
Diabetic nephropathy	26 (16)	3 (5)	8 (19)	15 (25)
Other/unknown	39 (24)	19 (32)	7 (17)	13 (21)
Previous dialysis	20 (12)	4 (7)	7 (17)	9 (15)
Dialysis vintage[b] (months)	32.5 (11.8–64.3)	32.0 (8.3–64.0)	21.0 (7.0–67.0)	51.0 (18.0–77.5)
Previous kidney transplant	37 (23)	10 (17)	11 (26)	16 (26)
Charlson comorbidity index	3.0 (2.0–5.0)	2.0 (2.0–3.0)	4.0 (2.0–5.0)	4.0 (2.0–5.5)
Hospitalization in the past 3 months	60 (39)	15 (27)	19 (46)	26 (46)
Current dialysis				
Dialysis modality				
Haemodialysis	130 (80)	49 (83)	34 (81)	47 (77)
Peritoneal dialysis	32 (20)	10 (17)	8 (19)	14 (23)
Acute start of dialysis	23 (14)	14 (24)	4 (10)	5 (8)
Clinical parameters				
BMI, kg/m^2	26.6±6.4	26.5±6.6	26.2±5.5	26.8±6.9
Residual diuresis[c]	141 (97)	51 (100)	38 (100)	52 (93)
Haemoglobin, mmol/L	6.8±1.0	6.9±1.2	6.9±1.0	6.8±0.9
Phosphate, mmol/L	1.73±0.53	1.79±0.55	1.68±0.50	1.72±0.54
Calcium, mmol/L	2.26±0.21	2.27±0.18	2.31±0.15	2.22±0.25
Albumin, g/L	37.5±6.4	38.5±5.0	37.2±5.5	36.8±8.0
Medication use				
Medications (mean), n	12.2±4.5	7.6±2.0	12.0±0.9	16.7±2.9
Medications (median), n	12 [9–15]	8 [6–9]	12 [11–13]	16 [14–19]
Polypharmacy[d]	158 (98)	55 (93)	42 (100)	61 (100)
Health-related quality of life				
SF-12 PCS	36.6±10.2	40.2±10.9	36.8±9.8	33.2±8.9
SF-12 MCS	46.8±10.0	49.1±9.1	47.8±10.2	44.1±10.3
Symptoms, n	12.3±6.9	11.0±6.3	9.7±6.6	15.5±6.7
Symptom burden	33.2±21.9	29.7±19.4	23.8±19.0	43.2±22.9
EQ-5D-5L utility score	0.71±0.24	0.80±0.18	0.75±0.23	0.61±0.27
Self-rated health	60.1±20.6	66.7±18.4	62.2±20.5	52.1±20.2

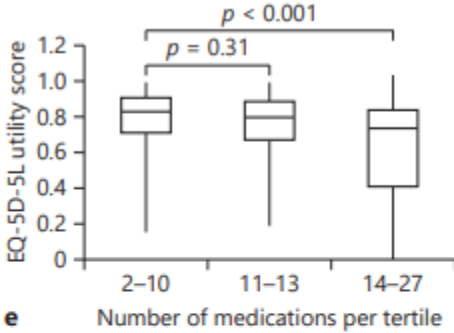
Polyfarmacie

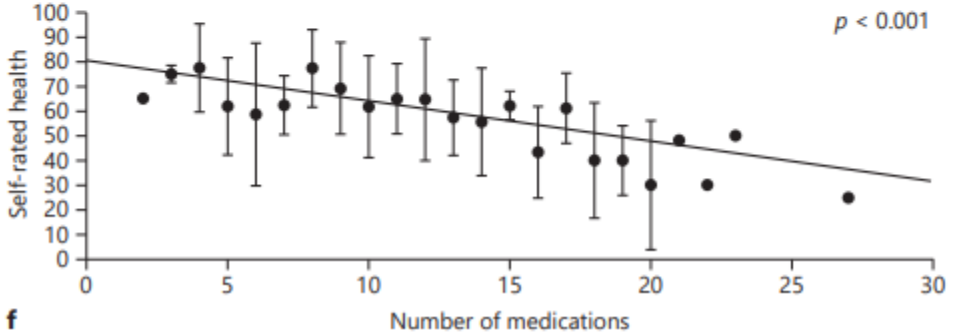












DOMESTICO
PROMs

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Klinische uitkomsten

DOMESTICO
Best Practices en SDM

Retrospectief

Best Practices en SDM

2012-2017	2018	2019	2020	2021

DOMESTICO BP&SDM

RESEARCH ARTICLE

Good practices for dialysis education, treatment, and eHealth: A scoping review

Anita van Eck van der Sluijs[1], Sanne Vonk[1], Brigit C. van Jaarsveld[2,3], Anna A. Bonenkamp[2], Alferso C. Abrahams[1]*

1 Department of Nephrology and Hypertension, University Medical Center Utrecht, Utrecht, The Netherlands, **2** Department of Nephrology, Amsterdam University Medical Centers, Location AMC, Amsterdam, The Netherlands, **3** Diapriva Dialysis Center, Amsterdam, The Netherlands

PLOS ONE | https://doi.org/10.1371/journal.pone.0255734 August 11, 2021

Retrospectief	Prospectief	BP&SDM	Mantelzorg

DOMESTICO BP&SDM

Nierfalen traject

Alle 'Good Practices'

1. Patiënt eigen baas over informatietraject
2. Gespecialiseerd verpleegkundige
3. Huisbezoek
4. Dialyse thuis of CHD
5. Multidisciplinair overleg
6. Wegnemen barrières
7. Voorlichting aan huis
8. Voorlichtingsfilms
9. Ervaringsdeskundigen

Inleiding

Dit document geeft een overzicht van Good Practices (met voor-en nadelen) op het gebied van de besluitvorming ten aanzien van de vervolgbehandeling bij nierfalen (aangeduid met nierfalentraject). De Good Practices zijn niet op wetenschappelijk bewijs gebaseerd en er is discrepantie tussen bepaalde Good Practices. Het is aan een ieder om zijn eigen weging toe te passen ten aanzien van de voor-en nadelen van de benoemde Good Practices.

Doelgroep

Artsen, verpleegkundig specialisten, nierfalenverpleegkundigen, dialyse verpleegkundigen en maatschappelijk werkers verbonden aan de afdeling Nefrologie.

Navigatie

Links in het menu vindt u onze Good Practices. Wanneer u deze aanklikt vindt u de voor-, en nadelen, een accordeon met inhoud en een afdrukbare PDF van het praktijkvoorbeeld.

Versie

17 april 2019

DOMESTICO BP&SDM

Workshop ‘Van voorlichting naar dialoog’

DOMESTICO Mantelzorgproject

- Doel: onderzoeken van het effect van starten met (thuis)dialyse op mantelzorgers van dialysepatiënten
  - positieve en negatieve ervaringen
  - verschillen tussen mantelzorgers van thuisdialysepatiënten en centrumdialysepatiënten.

- Mantelzorgers beter ondersteunen

De lessen uit DOMESTICO

- Samenwerking is de belangrijkste succesfactor
- Kwaliteit van leven is een belangrijke uitkomstparameter bij dialysepatiënten
- Samen beslissen is belangrijk

ZonMw

Nefrovisie
Zicht op nierzorg

nvn

Zorgverzekeraars Nederland

NIERSTICHTING
Leven gaat voor.

DOMESTICO

NIVEL
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Nederlandse Federatie voor Nefrologie

institute for Medical Technology Assessment

DIALYSE INDUSTRIE

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Dutch n**O**cturnal and ho**ME** dialysis **S**tudy **T**o **I**mprove **C**linical **O**utcomes

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