

# Choosing Wisely

## Five things physicians and patients should consider

### **1. Don't initiate chronic dialysis without ensuring a shared decision-making process involving both, the patients and their family.**

The decision to initiate chronic dialysis should be part of an individualized, shared decision-making process between patients, their families, and their physicians. This process includes eliciting individual patient goals and preferences and providing information on prognosis and expected benefits and harms of dialysis within the context of these goals and preferences. Limited observational data suggest that survival may not differ substantially for older adults with a high burden of comorbidity who initiate chronic dialysis versus those managed conservatively.

### **2. Don't perform oncological screening for asymptomatic patients in end-stage renal disease without having discussed risks and benefits.**

Due to high mortality among end-stage renal disease patients, oncological screening—including mammography, colonoscopy, prostate-specific antigen (PSA) and Pap smears—in dialysis patients with limited life expectancy, does not improve survival. False-positive tests can cause harm: unnecessary procedures, overtreatment, misdiagnosis and increased stress. An individualized approach to cancer screening incorporating patients' cancer risk factors, expected survival and transplant status is required

### **3. Avoid nonsteroidal anti-inflammatory drugs (NSAIDs) in individuals with hypertension, heart failure and/or CKD.**

The use of NSAIDs, including cyclo-oxygenase type 2 (COX-2) inhibitors, for the pharmacological treatment of musculoskeletal pain can elevate blood pressure, make antihypertensive drugs less effective, cause fluid retention and worsen kidney function. Other agents such as paracetamol, tramadol or short-term use of narcotic analgesics may be safer than and as effective as NSAIDs

### **4. Don't initiate erythropoiesis-stimulating agents (ESAs) to asymptomatic chronic kidney disease (CKD) patients with hemoglobin levels $\geq 10$ g/dL.**

Administering ESAs to CKD patients with the goal of normalizing hemoglobin levels has not demonstrated survival or cardiovascular disease benefit, and may be harmful in comparison to a treatment regimen that delays ESA administration or sets relatively conservative targets (9–11 g/dL). ESAs should be prescribed to maintain hemoglobin at the lowest level that both minimizes transfusions and best meets individual patient needs.

### **5. Avoid, if possible, to insert venous catheters in stage IV-V CKD patients in an arm potentially suitable for arteriovenous fistula.**

Venous preservation is critical for stage IV–V CKD patients. Arteriovenous fistulas (AVF) are the best hemodialysis access, with fewer complications and lower patient mortality, versus grafts or catheters. Excessive venous puncture damages veins, destroying potential AVF sites. PICC (peripherally inserted central catheters) lines and subclavian vein puncture can cause venous thrombosis and central vein stenosis. Early nephrology consultation increases AVF use at hemodialysis initiation and may avoid inappropriate PICC lines or central/peripheral vein puncture.