

©Borgis

*Elzbieta Milewska¹, Katarzyna Rzatkiwicz¹, Małgorzata Andryszczyk¹, Zbysław W. Grajek¹,
Ewa Kleszczewska¹, Jerzy Robert Ladny^{1,2}, Andrzej Sek¹

The impact of dialysis therapy on the quality of patients' life

Wpływ dializoterapii na jakość życia pacjentów

¹Department of Health Care, Prof. Edward Szczepanik State Higher Vocational School of Suwalki, Poland

²Department of Emergency Medicine, Medical University of Białystok, Poland

Keywords

chronic kidney disease, haemodialysis, quality of life

Słowa kluczowe

przewlekła choroba nerek, hemodializa, jakość życia

Conflict of interest

Konflikt interesów

None

Brak konfliktu interesów

Address/adres:

*Elzbieta Milewska
Department of Health Care
Prof. Edward Szczepanik State Higher
Vocational School of Suwalki
10 T. Noniewicza Str., 16-400 Suwalki,
Poland
Phone: +48 783687860
E-mail: ela_milewska@wp.pl

Summary

Recent years have seen an increased revival of interest and involvement in the quality of life in the field of many sciences, inter alia, philosophy, politics, social practices and medicine. In medicine the quality of life has been considered from the healthcare perspective. The study of the quality of life of dialysis patients involves recognizing many problems they face. Dialysed patients with chronic kidney disease deal with life limitations in somatic, emotional and psychosocial sphere. Renal replacement therapy entails sorrowful and persistent complications that contribute to malaise during and in between dialysis therapies. It needs to be stressed that treatment of the dialysis patient calls for knowledge, engagement and responsibility. Health care professionals, family and relatives should provide emotional support to the patient, sharing their knowledge and expertise. It has a considerable influence on the course and quality of life at every stage of the disease. Therefore, it is essential and well-founded to define what kind of support the ill person can rely on. It is crucial to spend time on educating the patient and his immediate family to help them cope with the disease. Ignorance about the disease adversely affects the process of coping with the disease. The emotional state of the ill person should be assessed to gauge the person's anxiety and depression levels. Education should also be an indispensable element of the healthcare and be accessible at every stage of the disease.

Streszczenie

W ostatnich latach jakość życia wzbudza coraz większe zainteresowanie i zaangażowanie w obszarze wielu nauk, m.in.: filozofii, polityki, praktyki społecznej i medycyny. W medycynie ta problematyka jest rozpatrywana w kontekście zdrowia. Badanie jakości życia chorych przewlekle dializowanych wiąże się z poznaniem wielu problemów, z jakimi muszą się uporać. W przypadku pacjentów z przewlekłą chorobą nerek, leczonych dializami, ograniczenia powstają w sferach: somatycznej, emocjonalnej i psychospołecznej. Terapia nerkozastępcza niesie za sobą skutki występowania przykrych i uporczywych powikłań. Wpływają one na złe samopoczucie w trakcie dializ i w okresie między nimi. Należy zauważyć, iż sprawowanie opieki nad pacjentem dializowanym wymaga wiedzy, zaangażowania i odpowiedzialności. Personel medyczny, rodzina i bliscy powinni wspierać chorego emocjonalnie oraz dzielić się swoją wiedzą. Ma to bardzo istotny wpływ na przebieg i jakość życia pacjenta na każdym etapie choroby. Dlatego bardzo ważne i zasadne jest, aby określić, na jakie wsparcie w środowisku domowym chory może liczyć. Konieczne jest poświęcenie czasu na edukację pacjenta i jego najbliższych, aby ułatwić zmagania z chorobą. Niewiedza na jej temat wpływa niekorzystnie na proces radzenia sobie z trudną sytuacją. Ważnym elementem jest badanie stanu emocjonalnego chorego w kierunku poziomu lęku i występowania depresji. Edukacja powinna stanowić nieodłączny element opieki i być dostępna w każdym stadium choroby.

INTRODUCTION

In recent years the issue of quality of life has been extensively researched. Since the 1980s of the twentieth century an increased interest in that issue has been observed in many fields of study. Taking on interdisciplinary dimension, the term quality of life has been

differently defined and interpreted by psychologists, sociologists, educators and representatives of medical sciences. In medical sciences the term began to creep in the 1970s of the previous century, being differently understood than in other fields of study. In medicine a new semantic category has been defined, termed

health-related quality of life (HRQOL), denoting the quality of life determined by the health condition, morbid processes, natural aging process, etc. The term 'quality of life' was first used in the United States of America after the II World War. The subject was broached to address the need for improvement of living conditions. Later it came to embrace improvements in education, health and happiness (1).

The aim of this paper has been to collect works of reference and show the quality of life of patients with chronic kidney disease subject to renal replacement therapy as well as point out treatment modalities for renal failure and the impact of dialysis therapy on the quality of life.

QUALITY OF LIFE OF A DIALYSED PATIENT

Renal replacement therapy is aimed at prolonging the life of the patient and improving his or her physical and mental well-being (2). According to the WHO the term 'chronic illness' refers to all disorders or abnormalities which have at least of one of the following features: may be permanent, may entail disability, are caused by irreversible pathological changes and last but not least, require special rehabilitation treatment, long-term supervision, observation or care (3).

A stress-inducing factor, chronic disease, such as renal failure which requires dialysis treatment, has a negative impact on the patient's future life. It is accompanied by the following emotions: anxiety, terror, despair, anger or fear for future life. Earlier procedures might disqualify patients, in particular elderly patients, from undergoing renal replacement therapy. Renal failure used to be a death sentence. Currently more dialysis centres are available and only a few illnesses are contraindication to treatment. Fortunately, age is not a delimiting factor (4, 5) as the risk of morbidity increases with age. The number of ill people amounts to 600 million worldwide, and 4.2 million in Poland (6), whereas the number of dialysed patients worldwide is about 1.5 million. According to the data of the National Coordinator for the Improvement and Development Dialysis Therapy Programme 14.000 people underwent renal replacement therapy in 2006 in Poland (6, 7).

Chronic kidney disease exerts a tremendous influence on quality of life, in particular, the life of dialysed patients. The aim of the renal replacement therapy is to replace the kidney function which stops as a result of permanent or irreversible changes. The main modes of treatment in chronic renal failure are dialysis therapy and kidney transplant. Dialysis therapy comprises peritoneal dialysis and haemodialysis, i.e. transperitoneal dialysis. The best renal replacement therapy is kidney transplant. Every dialysed patient should be considered to be a potential donor. Unfortunately, the occurrence of co-morbidities in dialysed patients and insufficient number of kidney donors often make it impossible to perform a transplant (8).

NEED FOR SUPPORTING A DIALYSED PATIENT IN ALL SPHERES OF LIFE

Renal replacement therapy impacts physical and psychological well-being, pervading social, occupational and family life, often causing lack of satisfaction with life. The disease is related to limitations in functioning in domestic and social life. Treatment is associated with daily life inconveniences and frequent hospital stays often due to co-occurring ailments and diseases. Frequent hospital visits may contribute to depression, fear, sleep disorders. Chronic illness impacts temporarily or permanently various aspects of the patient's life. However, renal replacement therapy has its advantages as it minimalizes the risk of uremia (9-11). Modality treatments and improved methods of treatment help patients feel better and lengthen their lives. Implementation of renal replacement therapy entails huge lifestyle changes. The patient is faced with constant challenges. Dialysis – related medical procedures require spending at least 8 hours in a dialysis centre every other day. The procedures determine lifestyle choices. Besides dialysed patients often complain of aches and pains and other typical complications: low blood pressure, generalized muscle weakness, muscle spasms, skin itching, chills, weakness, headaches and dizziness, shortness of breath, swelling, stomach upset and loss of appetite. In addition, renal replacement therapy entails limited fluid and food intake. For most patients CKD is a starting point of unceasing fears. The patient often perceives his or her disease as an event that has disturbed the whole life rhythm and has dispelled a sense of security. Increased fear is observed in the sphere of family, occupational and social life, interests, contacts with other people, physical activity and independence. Fear and anxiety of the patient result from changes in health condition, unpredictable effects of treatment, dialysis therapy procedures, unpredictable outcome of kidney transplant on which almost every dialysis patient counts as well as treatment regime. The affected people often feel a sense of loneliness and hopelessness, being plagued by thoughts of likely death or subjectively felt loss of essential vital functions (12, 13).

Dialysed patients are often overcome by feelings of low self-esteem and a sense of guilt. Obstacles to normal functioning and daily life limitations adversely affect self-perception, resulting in signs of withdrawal, self-acceptance problems or failure to establish and maintain social contacts. The character of medical procedures often makes the patients retire from professional life. Only few dialysed patients pursue gainful employment.

The most important role in self-acceptance and disease acceptance is played by the immediate family, family and friends. The cyclic pattern of dialysis therapies also influences the life of the whole family. The disease is a threat to a mental balance of the individual. Long-term treatment and frequent hospital stays also put a strain on the patient's family members (14). It needs to be mentioned that CKD poses a challenge

for both the patient and the patient's partner. Patients feel physically unattractive and have low self-esteem. The disease disrupts sexual activity and decreases libido. If the latter is the case, a sexologist or psychologist should be consulted. The subject is extremely rarely broached because patients feel self-conscious and are too embarrassed to talk about it (15).

Assessment of the quality of life of CKD patients focuses on various spheres of life, especially daily life, giving a comprehensive insight into all relations with other people, satisfaction levels, psychological well-being and activities undertaken in areas of life important to those patients. An all-embracing assessment facilitates planning immediate and long-term care, monitoring the effectiveness of drugs taken or modi-

fying treatment, which in turn translates into a better quality of life (16, 17).

There are many factors which deteriorate the quality of life of dialysed patients, inter alia, lack of disease acceptance and treatment methods, inability to cope with the disease, advanced age, bad emotional status, mood disorders, physical and dietary limitations, sexual disorders, lack of cooperation with the therapeutic team, limited occupational engagement and thus worse financial status, low self-esteem, weak bonds with the partner and missed opportunities for motherhood or social life. The factors concern all spheres of patient's life. Considering the above the patient should be provided with holistic care aimed at improvement of his somatic, mental, social and spiritual condition.

BIBLIOGRAPHY

1. Trzebiatowski J: Jakość życia w perspektywie nauk społecznych i medycznych – systematyzacja ujęć definicyjnych. *Hygeia Public Health* 2011; 46: 25-31.
2. Gętek M, Czech N, Białek-Dratwa A et al.: Jakość życia chorych poddawanych przewlekłe leczeniu nerkozastępczemu – przegląd piśmiennictwa. *Hygeia Public Health* 2012; 47: 151-156.
3. Kubus G, Sawicka J, Łagoda K et al.: Wpływ depresji na ocenę jakości życia pacjentów przewlekłe dializowanych. [W:] Łoboz-Grudziń K, Panaszką B, Uchmanowicz I (red.): *Jakość życia w chorobach wewnętrznych*. Wrocław 2008: 91-97.
4. Krasnodębska-Tomkiel M: Decyzja nr DKK-70/11, DKK2-421/3/11/DL. Warszawa 28 czerwca 2011.
5. Wiśniewska L, Paczkowska B, Białobrzęska B: Zapotrzebowanie na wsparcie emocjonalne wśród pacjentów leczonych nerkozastępczo. *Forum Nefrol* 2010; 3: 63-65.
6. Rutkowski B: Dostępność i jakość leczenia nerkozastępczego w krajach Unii Europejskiej w świetle badania CEAPIR. *Forum Nefrol* 2012; 5(4): 330-346.
7. Zdrojewski Z: Poprawa efektywności leczenia nerkozastępczego chorych z krańcową niewydolnością nerek. *Forum Nefrol* 2008; 1: 13-21.
8. Pietrzyk AJ, Dyras P: Techniki nerkozastępcze. *Ogólnopol Prz Med* 2006; 4: 38-41.
9. Breza B: Źródła niepokoju pacjentów długotrwale hemodializowanych. *Psychiatria w Praktyce Ogólnolekarskiej* 2007; 1(7): 8-14.
10. Ziarko E, Orzeł-Nowak A, Rak A: Jakość życia pacjentów z niewydolnością nerek. *Mag Pielęg Położ* 2001; 43(2): 4-8.
11. Misiewicz A, Różański J, Marchelek-Myśliwiec M et al.: Problemy psychospołeczne chorych przewlekłe dializowanych. *Post Nauk Med* 2001; 3: 188-191.
12. Gętek M, Nowakowska-Zajdel E, Czech N et al.: Jakość życia pacjentów dializowanych i po przeszczepie nerek. *Ann Acad Med Siles* 2010; 64: 23-30.
13. Rutkowski B (red.): *Leczenie nerkozastępcze w praktyce pielęgniarskiej*. Via Medica, Gdańsk 2008: 185-188.
14. Kurowska K, Weselska M: Rola wsparcia a przystosowanie się do życia osób dializowanych. *Nefrol Dial Pol* 2015; 19: 161-165.
15. Kapka-Skrzypczak L, Lipin B, Niedźwiecka J et al.: Subiektywna ocena jakości życia pacjentów dializowanych metodą dializy otrzewnowej oraz hemodializy. *Probl Hig Epidemiol* 2012; 93(4): 790-797.
16. Maniutis J, Sulikowska B: Wpływ leczenia farmakologicznego na jakość życia u chorych z przewlekłą niewydolnością nerek. *Nefrol Dial Pol* 2001; 5: 67-69.
17. Nowicki M, Jagodzińska M, Murlikiewicz K et al.: Aktywność fizyczna chorych przewlekłe dializowanych – porównanie skuteczności różnych metod jej zwiększania. *Post Nauk Med* 2009; 10: 779804.

received/otrzymano: 05.07.2018
accepted/zaakceptowano: 26.07.2018