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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Current Experiences in Identifying and Treating Itch in Patients on Hemodialysis

Announcer
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Chapter 1

Dr. Burton:
We know that patients with chronic kidney disease may be experiencing severe itch known as CKD-associated pruritus, or CKD-aP. And itching and related symptoms, such as reduced sleep and depression, can have a really negative impact on the quality of life of the patients that we look after. Using real-world patient cases, we're going to discuss how to identify and treat itch, provide relief from itch-related symptoms, and improve quality of life in our patients with CKD-aP.

This is CME on ReachMD, and as I said, I'm Dr. Jim Burton.

Dr. Pollock:
And I'm Dr. Carol Pollock.

Dr. Burton:
So Carol, like me, you look after a lot of people on dialysis, and have a lot of experience looking after people with itch so let's start by looking at a case.

Dr. Pollock:
Well, I thought I'd talk about a 33-year-old who actually had primary oxaluria but really the cause of his kidney disease isn't relevant. He'd never complained of itch, but the nursing staff had actually noted severe scratch marks around his access and questioned him about whether he had itch. And in fact, he had severe, generalized pruritus, and this was interfering with his sleep, his mood, and his social functioning. So we looked at his dialysis. It was fairly optimal. We looked at giving him standard therapies with emollients, and did a Worst Itch Scale on him, a WI-NRS. And basically he scored the highest that you could score, 10 out of 10.

So in addition to these background therapies that we can discuss, we started him on difelikefalin 3 times a week and, in fact, his itch improved remarkably. So he went from the scale, the top of the scale, down to the bottom of the scale after several weeks of therapy, 6 weeks. His quality of life improved remarkably, just in this short period. So I think it really highlights the issue that people don't complain about itch unless they're specifically questioned about it, and if we don't know about it, we can't treat it appropriately.

Dr. Burton:
I think you touch on a really important point there, actually, that many people just don't mention itch at all to their attending nephrologist or, indeed, some people to anyone at all. So I mean, how did you confirm that this person was suffering from CKD-associated pruritus?

Dr. Pollock:
So basically I excluded the other causes of itch, and then in the absence of any other cause of itch, I think it's reasonable to assume that he does have CKD-associated pruritus, as do about 40% of hemodialysis patients. But of course, we vastly underdiagnose this.

Dr. Burton:
I think that's absolutely right. We saw in a recent survey of nephrologists that about half of nephrologists agree that CKD-associated pruritus is underdiagnosed.

And we know from DOPPS data that somewhere around 15% of people, even with moderate to severe itch, would not tell anybody about their symptoms at all, and the reasons behind that are multifactorial. It might be that they think it's not associated with their kidney disease. You talked about many other causes of itch, and it might be that they just don't think that it's associated with their kidney disease. And I think an awful lot of patients don't think that we can do anything about it even if they do mention it, and they don't want to burden staff by talking about things when they see them so busy on the units if they don't think there's anything that can be done about it. And so I think you mentioned, Carol, it's really important for us to be very proactive in going and asking people about their symptoms. And yet, less than 20%, again, in that survey of nephrologists, less than 20% of units, as far as we know, actually have a systematic approach to screening for symptoms like itch.

And so I guess that's the kind of perfect storm, really, isn't it, that patients don't necessarily talk about it, we don't have a structured way in which we ask people about it, and ultimately an awful lot of the people that we look after on dialysis end up suffering in silence with their symptoms.

Dr. Pollock:
No, I couldn't agree more. And obviously focusing on a patient's psychosocial situation, particularly on dialysis, is very important and we increasingly recognize that.

Chapter 2

Dr. Pollock:
So it's important to look at the severity of itch, which is the Worst Itch Scale, if you like, from 1 to 10. And if we look at that scale, then measures between 1 and 2 are mild, between 3 and 6 are moderate, between 7 and 8 are severe, and between 9 and 10 are very severe. And of course, this patient had an itch scale of 10.

And then it's also reasonable to then look at how it's affecting the quality of life. So this is done usually by a self-assessment disease severity score, but it's also important to ask about aspects of other things that itch can impede upon, such as sleep and social interactions and mood disturbances. Because things like mental health is very adversely affected by itch. And I think as clinicians, we often focus on the numbers rather than on the quality of life of patients, which patients report as itch being a significant impediment to their quality of life.

So I think that now we do actually see that there are treatments that are appropriate to introduce in people that are complaining of itch. So I think in people with mild itch, or even up to moderate itch, we really do need to be optimizing dialysis and focusing on the calcium phosphate homeostasis and their parathyroid hormone levels, although none of these actually correlate very well with itch. So if they're normal, we can't assume that this isn't CKD-associated pruritus.

So the mainstay of mild therapy is really emollients and moisturizing the skin, as well as avoiding sweating, so wearing appropriate clothing in hot weather, etc., and also using non-alkaline, non-perfumed soap, not having terribly hot baths, and maybe oatmeal baths may be of symptomatic relief. And I think people also use antihistamines, but really they just cause drowsiness and may exacerbate social withdrawal, etc., so these are not recommended for itch.

If we look at things like the pentinoids, gabapentin has significant side effects. It can cause drowsiness, it's associated with increased suicide, actually, so very negative outcome, weight gain, and it's difficult to use in dialysis because it's dialyzed off. And the same with Lyrica.

So if we look at the pathophysiology, itch is really an imbalance between the kappa- and the mu-opioid receptors. And difelikefalin was actually developed in recognition that itch was a significant issue for patients. And so this is an agonist of the kappa receptors that normalizes the relationship and improves the problem.

And I think the real-world experience demonstrates that about 64% of people actually get benefit within 2 to 3 weeks of starting the treatment. So why wouldn't we use it?

So when we approached this in Australia, and I recognize that it's different across jurisdictions, we really have a multidisciplinary

approach, because we recognize nurses are often the people that identify the problem. We need psychologists to cope with some of the issues, and we know that itch doesn't occur in isolation; it occurs with all of these other consequences of mental health problems, etc. But to prescribe difelikefalin in Australia, somebody needs to be on dialysis for 3 months. They need to have a WI-NRS score of greater than 4, and after 3 months of treatment with difelikefalin it needs to have improved by at least 3 points for it to continue. It needs to be started by a nephrologist, but we're pushing that it should be able to be subsequently supplied by a nurse practitioner, because they often have the best interaction with patients.

And we know that from the KALM studies and specific quality of life studies, there's a 35% improvement in sleep and a significant improvement in mental health and social functioning and quality of life overall. So I think we have good treatments, and yet we don't use them. So we should be much more empowered to rapidly go through these early emollients and moisturizers, etc., and then use difelikefalin when appropriate.

Dr. Burton:
And as you've said, that evidence from the KALM-1 and KALM-2 studies show us that there is something that is licensed now. Difelikefalin is also available and has been reviewed by NICE [National Institute for Healthcare and Excellence], is clinically and cost effective, so we have that available and reimbursed in the UK.

Dr. Pollock:
I think our best treatment at present for moderate to severe itch remains difelikefalin.

Dr. Burton:
And you mentioned that 60% of people would see a significant improvement in that early stage. And actually, as that gentleman that you sort of mentioned, 30% of people get complete resolution within that period of time, which is extraordinary.

Dr. Pollock:
So, Jim, I'd like to hear how you actually validate CKD-associated pruritus screening in patient-reported outcomes and the tools that you're using in your practice.

Dr. Burton:
So for those just tuning in, you're listening to CME on ReachMD. I'm Dr. Jim Burton, and here with me today is Dr. Carol Pollock, and we're discussing how to identify and treat CKD-associated pruritus in people on hemodialysis using patient case studies.

So, well, I'll perhaps think about a person that I can bring to mind, a case that I can bring to mind. It was a woman in her 70s. She had a history of hypertensive disease. That's why she has end-stage kidney disease. But Carol, like you said, really the underlying kidney condition is largely irrelevant to the management of pruritus. And I remember seeing her, and the nurses had said to me, she was using a back scratcher, she was actually using a hairbrush to scratch. And she had people kind of helping her so that she could sleep. You mentioned about sleep, but sleep is so important to people that we look after on dialysis, because fatigue is such a big problem anyway. But it was impacting sleep significantly and she was on chlorpheniramine, on an antihistamine tablet, as well as pregabalin, a gabapentinoid, to try and help with itch. And really, none of those had made a significant impact. And she was using regular emollients.

But none of those things have really got on top of things. And we use you mentioned the Worst Itch Numerical Rating Score, so a 0 to 10 score, really straightforward and simple for patients to fill in, was used as the primary endpoint for the KALM studies, as you mentioned. And this particular lady saw an improvement of 4 points on the WI-NRS score. And we know that a 3-point improvement is clinically meaningful to people with itch. So we're aiming for a 3-point or more improvement as they set in the studies, the KALM studies. So she had a 4-point improvement in her itch.

We know that for patient-reported outcome measures, not every tool is perfect, and the WI-NRS, for example, would ask patients: how bad has your itch been in the last 24 hours? And so, as you said, again, we know that itch can be very intermittent, it can affect different parts of the body in different people, and so it can be very individual. So it might be that somebody didn't feel itchy in the last 24 hours, but they do feel itchy regularly, nevertheless.

And we know, again, from the studies that if we can get a greater than 3-point relief from itching on the WI-NRS, that that has a significant improvement in sleep, in mood, and as a consequence to that, we know that people are less likely to miss their dialysis sessions and actually less likely to be admitted to hospital for some of the complications around that.

Dr. Pollock:
I think some of those issues are really important because we've obviously been focusing on quality of life and sleep and mental health, but actually itch is associated with significant infectious complications and actually an increased risk of death.

Dr. Burton:

I guess going back to that question that you asked of me, Carol, which is how do we do that in our units, I would say that the most important thing is to say, just go out there and ask. Not all tools are the same, but the key is to capture as many people who are itching. Because if we don't ask, then we know that a lot of people just won't say anything at all.

Dr. Pollock:
And I think the simplicity of the WI-NRS is what makes it attractive for busy clinicians.

Dr. Burton:
Absolutely. And there are other tools for itch, the Skindex-10, for example. There's a question about itch in the KDQOL. And I know, again, in other geographical areas, people use the KDQOL annually. So there are other ways of measuring it and capturing that data. And I guess the other thing to be really clear of is, if we are asking, we must listen.

Before we wrap up, Carol, can you share one takeaway message with our audience?

Dr. Pollock:
I think it's important to consider that as nephrologists we've always focused on biochemical outcomes and clinical outcomes, and perhaps we haven't focused on the quality of life of patients. And yet, patients report that quality of life is extremely important to them. And we recognize now that itch is associated with a reduced quality of life, and we can do something about it, so we should.

Dr. Burton:
And I think, then, in leading on from that, my take-home message would be that as a whole clinical team, a whole multiprofessional clinical team looking after people on dialysis, that we should be asking more often, do you itch? We should quantify that with a validated tool like the WI-NRS, and we should do that proactively. And then we should listen to the answer and do something about it.

So I want to thank our audience for listening in and thank you, Dr. Carol Pollock, for joining me and sharing all of your valuable insights. It was great speaking with you today.

Dr. Pollock:
And me with you.

Announcer
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