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Why We Should Be PRO Patients With CKD-Associated Pruritus

Announcer:
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Dr. Manenti:
Chronic kidney disease-associated pruritus, or CKD-aP, severely impacts the quality of life of our patients with CKD, particularly those with end-stage renal disease. Assessing the frequency and intensity of CKD-aP has been a challenge in clinical practice. Today, we will discuss the utilization of patient-reported outcomes, PROs, in guiding treatment choices and the importance of multidisciplinary care to optimize the management of patients with CKD-aP.

This is CME on ReachMD, and I'm Dr. Lucio Manenti.

Dr. Finderup:
And I'm Dr. Jeanette Finderup.

Dr. Koball:
And I'm Sebastian Koball.

Dr. Manenti:
We have a lot to discuss today, so let's begin.

Sebastian, how can we monitor and measure PROs to improve the quality of life of our patients?

Dr. Koball:
Uremic itching is not just there for a few minutes or for an hour, as we know it from a mosquito bite or something like that. It is always there and that is very, very bad for our patients. It interferes with many things in their daily lives, for example, with their ability to concentrate, to sleep, and communication with other patients or with other relatives, and it also affects the well-being of our patients. And it has been proven that patients with itching have a very increased mortality rate. They suffer from skin injuries and associated infections. Many patients do not want to talk about itching as it is also associated with the already-mentioned social stigma. Explicitly asking about itching is the first priority in making the diagnosis of itching. Other causes of itching should be verified very carefully. It is important to ask about allergies and the manifestation area of itching on the skin. A physical examination can provide further clues and particularly attention should be paid to dry skin. Dry skin is a big problem in dialysis patients.

Visual analogue scales are very suitable for asking our patients about the stress caused by the itching and also for monitoring the progress and checking the effectiveness of our treatment. We recommend the Worst Itch Numeric Rating Scale. This is a very easy-to-perform rating scale. It is very important to regularly ask our patients about itching. This should be integrated into established routines, and in my opinion, it should be repeated at least every 3 months.

Dr. Manenti:
One of the greatest difficulties in measuring itch in dialysis patients lies in the fact that it can only be measured with patient-reported outcomes, and it is not always possible for the elderly patient to report adequately their complaints in a measurable way. It is also highly relevant to monitor CKD-aP over time. Approximately monthly, bimonthly, every 3 months, and normally with easily administered scales can this be achieved. That is why it is better to provide simple and time-saving tests such as the Worst Itching Numerical Rating Scale, as you say, and also, another simple scale that is useful and simple is the Self-Assessed Disease Severity Scale because it is able to represent better also the quality of life.

Jeanette, how can nurses best optimize the use of PROs in CKD to improve the quality of life in our patients?

Dr. Finderup:
CKD-associated pruritus is a symptom, and symptoms are self-reported. And it's a subjective perception of a physical and a psychological disturbance, and they are usually unpleasant and can only be identified by the individual experiencing them. The nurse who is the staff who work most closely with the patient, and so maybe the patient will report to her about the symptoms, but also maybe she will observe signs of the symptoms such as itching marks or itching behaviors. Nurses have to be systematically identifying CKD-associated pruritus, and using a patient-reported outcome tool is able, at a minimum, to measure the prevalence and the severity of pruritus. And patients with advanced chronic kidney disease, they experience a huge amount of symptoms, not just CKD-associated pruritus. So I would suggest to use a tool which is able to identify several symptoms of the uremic symptoms, and it could, for example, be the IPOS-renal or the Edmonton scale. Then you could go further on and use the 5-D itch scale, which provide a lot of information such about duration, direction, disability, and distribution.

Dr. Manenti:
I agree completely with you. The surveillance role of nurses that are in contact with the patient 3 times weekly is an added value.

Sebastian, based on what we heard from Jeanette, how important is implementing a multidisciplinary approach when managing patients with CKD-aP, in your opinion?

Dr. Koball:
I completely agree with Jeanette. The diagnosis of uremic pruritus is a multidisciplinary challenge, and not only the dialysis staff is responsible for that. I think the dermatologist should be involved, especially in the initial diagnosis, in order to rule out other rare skin diseases. A skin biopsy can rule out other diseases, but in my opinion, it is not absolutely necessary for the diagnosis of uremic pruritus. However, the initial response of the patient with regard to itching, and in particular the follow-up and therapy adjustment, is a task of the nephrology staff. I think both doctors and nurses should regularly ask about itching, observe the patients also on dialysis, and also look out for suspicious skin changes and places of stretching. The diagnosis and the treatment of itching is a long-term task as there can be often seasonal fluctuations in the severity of the itching, and itching can also first appear years after the start of dialysis. Regular questioning and documentation of the symptoms is very, very important for our patients, and it should be firmly integrated into the care of the dialysis patient.

Dr. Finderup:
The management of CKD-associated pruritus is a collaboration between a nephrologist and a dialysis nurse, I totally agree, because the management of pruritus is both pharmacological and nonpharmacologic, and it needs both physical management and psychological management. And to achieve a good outcome of this management of pruritus, you need all 4 types of management. And I think nurses have specific skills in nonpharmacological management, which is recommended as the first step, but the nurses also have specific skills in psychological management, learning the patient to cope with the situation. But more important, and another point, is management of pruritus first of all about shared decision-making. Making an informed and shared decision about the management that is right for the patient and with the patient, and also to provide self-management support to the patient by developing knowledge, skills, and confidence among the patient so he is able to manage the pruritus effectively. And then I also have, like, a third point. We should also involve informal caregiver so the informal caregiver is able to support the patient. So maybe I have like a broader view of the multidisciplinary team. It's not just the nephrologist and the dialysis nurse and the dermatologist; it's also the patient and the informal caregiver.

Dr. Manenti:
Those are some great points.

Sebastian, what is your management approach for patients with CKD-aP to relieve their itch burden?

Dr. Koball:
Increasing the dialysis dose is what we all did in the former times. And we did it through longer or more frequent dialysis. This has not always an effect on the pruritus of our patients. Antihistamines, sedatives, antidepressants, or even conventional opioid analogues are

often tried with more or less effect. Providing the patient with moisturizing creams is very, very important because the dry skin is a real problem. This should always be the first priority.

Treatment with appropriate creams is effective and has only a few side effects. Another new option is difelikefalin and is still relatively new on the map in Europe and other areas. This is a new kappa-opioid agonist. We have good experiences in our practice up to date.

And, Lucio, perhaps you can shed some light on the efficiency and safety of novel therapies like difelikefalin?

Dr. Manenti:
I agree completely with your therapies before we try novel therapies. We must stabilize the symptom and be sure that we are in front of uremic itch. And after that, we have the studies that confirm that difelikefalin is the first approved treatment for CKD-aP. Finally we have some large studies, KALM-1 and KALM-2, evaluated the efficacy and safety of difelikefalin in more than 800 patients. That is really the biggest study about CKD-aP. And difelikefalin was shown to reduce Worst Itch in Numerical Rating Scale by at least 3 points compared to placebo in 50% of the treated cases. And moreover, it leads to normalization of sleep, which is one of the big problems concerning quality of life for these patients, and it increased dramatically the mortality of the patient. And in open-label studies, the Worst Itch Numerical Rating Scale pre and post comparison showed also a significant improvement in more than 70% of cases. With regard to safety, it should be noted that difelikefalin is an opioid drug, but it does not cross the blood-brain barrier, so it has demonstrated the almost complete absence of central nervous system disturbances. Moreover, recently, a randomized controlled trial showed that the group discontinuing chronic difelikefalin treatment in patients undergoing hemodialysis does not produce the signs or symptoms of physical withdrawal. In contrast, opioid interference with the gastrointestinal system may lead to diarrhea in a small percentage of patients.

Jeanette, can you tell us more about the instrumental role nurses play in the success of treatment for patients with CKD-aP?

Dr. Finderup:
Of course. The nonpharmacological treatment is keeping the skin cool by using a fan, wear light clothing, or using cotton sheets. And the second principle is keeping the skin hydrated by using a humidifier, avoid hot showers, and use lukewarm water instead, and avoid excessive bathing.

And a third principle is about keeping the skin whole by avoiding skin irritants such as wool and use fragrance-free soaps and detergents and keep fingernails trimmed, and maybe also wear cotton gloves at night. But maybe the most difficult is just learning the patient to stop itching.

Dr. Manenti:
Well, this has certainly been a fascinating conversation, but before we wrap up, can you both share your take-home message with our audience?

Dr. Finderup:
Nurses need to assess pruritus, they have to use a validated tool, and the management of pruritus have to be based on shared decision-making and self-management support, and nurses have to reassess pruritus and, of course, working in collaboration with a multidisciplinary team.

Dr. Koball:
In diagnostics, the most important thing is to constantly ask the patient about symptoms. And in therapy, there are new hopeful options, I think, and we should offer them to our patients.

Dr. Manenti:
We finally have an approved therapy for the treatment of CKD-aP. This is why it is essential to start studying the symptom more precisely in order to finally understand why it appears, the fluctuations of the timing of the symptom, the importance of additional therapeutic aids, such as difelikefalin, in alleviating this very annoying symptom that leads to increased mortality due to worsening quality of life.

And that's all the time we have today. So I want to thank our audience for listening and thank you both, Dr. Finderup and Dr. Koball, for joining me and for sharing all of your valuable insights and expertise. It was great speaking with you today.

Dr. Findeup:
Thank you.

Dr. Koball:
Thank you very much.

Announcer:
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