Outcome of hemodialysis in elderly diabetic patients: a single-center experience
Hatem Darwish, Ahmed Fathi

Department of Internal Medicine and Nephrology, Cairo University, Cairo, Egypt
Correspondence to Hatem Darwish, MD, Kasr Al Ainy St. Cairo 11562, Egypt
Tel/Fax: (202)23682030; e-mail: hatem_darwish@hotmail.com
Received 17 February 2015
Accepted 06 April 2015
The Egyptian Society of Internal Medicine 2015, 27:87-91

Introduction
Nephrologists have recognized that the number of elderly patients with chronic kidney disease stage 5 (CKD5) has been increasing over the past 5 years [1]. The European registry shows that 48% of new dialysis patients are above the age of 65 and have a 2-year survival rate of 51% [2,3]

The optimal renal replacement therapy for elderly patients is unclear, and literature is evolving in this regard. The concept of maximal conservative management or even withdrawal of dialysis is under active discussion among nephrologists. The rationale behind this is that elderly patients not only suffer from CKD but also from varying degrees of frailty and additional comorbidities. In such situations, initiation of renal replacement treatment might not be the best option as it might not improve the quality of life, nor improve survival [4,5].

In our current study we tried to focus on elderly diabetic patients above 65 years, as they constitute the more vulnerable subgroup, having multiple comorbid conditions. The primary objective was to study the patient’s survival and the association with different comorbidities.

Patients and methods
As per hospital ethical and research committee and also as per international research ethics code no consent is required for retrospective archived file research.

We conducted a retrospective study reviewing the patients admitted to the Dialysis Unit at Dr. Erfan and Bagedo Hospital over 2007–2013 after obtaining approval from the ethical committee of the hospital.

Selection criteria
(1) Presence of type 2 diabetes.
(2) Age 65 years or more.
(3) CKD5 on dialysis.

We excluded patients with a history of malignancy, patients with diseases requiring immunosuppressive treatment, and those who died within three months of initiation of treatment.

A total of 48 patients were identified with a mean age of 70.8 ± 4.7 years and a mean duration of dialysis and follow up of 32 ± 18 months.

Patient files were reviewed for:
(1) Vascular access.
(2) Comorbid conditions such as coronary artery disease (CAD), peripheral vascular disease (PVD), and cerebrovascular disease. Documenting of comorbidities depended on diagnoses established.
by the corresponding specialty and appropriate imaging studies.
(3) Autonomy, whether independent, wheel chair dependent, or completely bedridden.
(4) Cognitive functions and depression as documented by psychiatric evaluation and medications.

**Statistical analysis**

Data were analyzed using an IBM computer with statistical package for the social sciences (SPSS, version 12; SPSS Inc., Chicago, Illinois, USA) as follows [6]:

(1) Description of quantitative variables as mean, SD, and range.
(2) Use of the unpaired t-test to compare quantitative variables in parametric data (SD<50% mean).
(3) Use of the Mann–Whitney test instead of the unpaired t-test when SD was greater than 50% of the mean.
(4) Use of the \( \chi^2 \)-test to compare qualitative variables between the two groups.
(5) Use of the Fisher exact test instead of the \( \chi^2 \)-test when one expected cell was less than 5.

\( P \) values greater than 0.05 were considered insignificant.
\( P \) values less than 0.05 were considered significant.
\( P \) values less than 0.01 were considered highly significant.

**Results**

Tables 1–3 show the demographic and comorbid conditions of the studied cohort.

Tables 4–7 show the association of depression, cognitive stat, autonomy, and mortality. Our results showed significant association between previous cerebrovascular accident (CVA) and lost autonomy and mortality (Tables 6 and 7), and no association of sex, vascular access, PVD, or mortality.

**Discussion**

In our studied cohort, the cutoff age for being considered elderly was 65 years. This cutoff point, which defines elderly, is debatable and inconsistent in different authorities. The common use of a calendar age to mark the threshold of old age assumes equivalence with biological age; yet at the same time it is generally accepted that these two are not necessarily synonymous. While the WHO considers 60+ as the cutoff point, most developed countries have accepted the chronological age of 65 years as a definition of ‘elderly’ or older person [7–9].

18.7% of the studied patients had depression, 12.5% had dementia, 20.8% died, and 20.8% of the studied cases were bedridden.

Taking into consideration the economic and cultural status of the Kingdom of Saudi Arabia, it was more appropriate to apply the age of 65+ to define elderly.

Our study showed a mortality of 20.8% (10/48 patients) with a mean duration of 32.4 months for hemodialysis (7.55% per year). The mortality was significantly correlated with prior CVA, lost autonomy, and cognitive impairment.

Survival data for elderly diabetic patients are seldom reported separately [10].

In elderly persons, mortality rates worsen with kidney disease more than in other groups. In the general US
The incidence of stroke is much higher in CKD patients than in the general population. The United States Renal Data System (USRDS) and National Inpatient Sample (NIS) studies reported by Dialysis Outcome and Practice Patterns Study (DOPPS) consistently show a marked difference in crude mortality between different countries, with mortality in the USA being one of the highest. For example, in 2003, DOPPS reported the crude 1-year mortality rate to be 6.6% in Japan, 15.6% in Europe, and 21.7% in the USA [12]. In DOPPS III, 8161 in-center hemodialysis patients participated; the median follow-up was 18 months. During the study period, 1337 participants died (crude mortality rate for all study participants was 12.2/100 patient-years, with mortality rates of 3.7, 10.4, and 21.4 deaths per 100 patient-years for patients <45, 45–74, and ≥75 years of age, respectively) [13].

### Table 4 Relation between psychiatric disorder and different variables

| Variables | Psychiatric [N (%)] | χ² | P |
|-----------|---------------------|----|---|
| Sex       |                     |    |   |
| Male      | 21 (53.8)           | 0.2| >0.05 (NS) |
| Female    | 18 (46.2)           |    |   |
| CAD       | 24 (61.5)           | Fisher <0.05 (S) |
| CVA       | 15 (38.5)           | Fisher <0.001 (HS) |
| PVD       | 5 (12.8)            | Fisher >0.05 (NS) |
| Expired   | 8 (20.5)            | 2.22 | Fisher >0.05 (NS) |
| Access    | 31 (79.5)           | Fisher >0.05 (NS) |
| Fistula   | 19 (48.6)           | 6.67 | >0.05 (NS) |
| Graft     | 17 (43.6)           | 2.22 | Fisher >0.05 (NS) |
| Catheter  | 3 (7.7)             | 1.11 | Fisher >0.05 (NS) |
| Age       | 70.6 ± 4            | 71.8 ± 5.7 | 0.9 | >0.05 (NS) |
| Duration  | 31.9 ± 16           | 32.8 ± 18.9 | 0.8 | >0.05 (NS) |

The higher frequency of CVA and CAD in the depressed group compared with the normal group, with statistically significant difference, using the Fisher exact test. CAD, coronary artery disease; CVA, cerebrovascular accident; HS, highly significant; PVD, peripheral vascular disease; S, significant. *Unpaired t-test. *Mann–Whitney test.

### Table 5 Relation between cognitive outcome and different variables

| Variables | Cognitive [N (%)] | χ² | P |
|-----------|-------------------|----|---|
| Sex       |                    |    |   |
| Male      | 21 (50)            | 4 (66.7) | 0.2 | >0.05 (NS) |
| Female    | 21 (50)            | 2 (33.3) |    |   |
| CAD       | 27 (64.3)          | 6 (100) | Fisher <0.05 (S) |
| CVA       | 18 (42.9)          | 6 (100) | Fisher <0.05 (S) |
| PVD       | 6 (14.3)           | 1 (16.7) | Fisher >0.05 (NS) |
| Expired   | 7 (16.7)           | 2 (50) | Fisher >0.05 (NS) |
| Access    | 35 (83.3)          | 3 (50) | Fisher >0.05 (NS) |
| Fistula   | 20 (47.6)          | 5 (83.3) | 1.8 | >0.05 (NS) |
| Graft     | 19 (45.2)          | 0    | Fisher >0.05 (NS) |
| Catheter  | 3 (7.1)            | 1 (16.7) | Fisher >0.05 (NS) |
| Age       | 70.6 ± 4           | 71.8 ± 5.7 | 0.9 | >0.05 (NS) |
| Duration  | 31.9 ± 16          | 32.8 ± 18.9 | 0.8 | >0.05 (NS) |

The higher frequency of CVA, mortality, and CAD in the dementia group compared with the normal group, with statistically significant difference, assessed using the χ²-test. CAD, coronary artery disease; CVA, cerebrovascular accident; HS, highly significant; PVD, peripheral vascular disease; S, significant. *Unpaired t-test. *Mann–Whitney test.

### Table 6 Relation between autonomy and different variables

| Variables | Autonomy [N (%)] | χ² | P |
|-----------|-----------------|----|---|
| Sex       |                 |    |   |
| Male      | 19 (54.3)        | 6 (46.2) | Fisher >0.05 (NS) |
| Female    | 16 (45.7)        | 7 (53.8) |    |   |
| CAD       | 22 (62.9)        | 11 (84.6) | Fisher >0.05 (NS) |
| CVA       | 12 (34.3)        | 12 (92.3) | Fisher <0.001 (HS) |
| PVD       | 5 (14.3)         | 2 (15.4) | Fisher >0.05 (NS) |
| Survived  |                 |    |   |
| Alive     | 30 (85.7)        | 8 (61.5) | Fisher <0.05 (S) |
| Expired   | 5 (14.3)         | 5 (38.5) | Fisher >0.05 (NS) |
| Access    |                 |    |   |
| Fistula   | 17 (48.6)        | 8 (61.5) | 0.8 | >0.05 (NS) |
| Graft     | 15 (42.9)        | 4 (30.8) | Fisher >0.05 (NS) |
| Catheter  | 3 (8.6)          | 1 (7.7) | Fisher >0.05 (NS) |
| Age       | 70 ± 4           | 72 ± 5 | 1.2 | >0.05 (NS) |
| Duration  | 30 ± 18          | 32 ± 22 | 0.4 | >0.05 (NS) |

The higher frequency of CVA and mortality in the assisted group compared with the normal group, with statistically significant difference, as assessed with the Fisher exact test. CAD, coronary artery disease; CVA, cerebrovascular accident; HS, highly significant; PVD, peripheral vascular disease; S, significant. *Unpaired t-test. *Mann–Whitney test.

### Table 7 Relation between mortality and different variables

| Variables | Survival [N (%)] | χ² | P |
|-----------|-----------------|----|---|
| Sex       |                 |    |   |
| Male      | 18 (47.4)        | 7 (70) | Fisher >0.05 (NS) |
| Female    | 20 (52.6)        | 3 (30) |    |   |
| CAD       | 25 (65.8)        | 8 (80) | Fisher >0.05 (NS) |
| CVA       | 15 (42.1)        | 8 (80) | Fisher >0.05 (NS) |
| PVD       | 6 (15.8)         | 1 (10) | Fisher >0.05 (NS) |
| Access    |                 |    |   |
| Fistula   | 18 (47.4)        | 7 (70) | 2 | >0.05 (NS) |
| Graft     | 17 (44.4)        | 2 (20) | Fisher >0.05 (NS) |
| Catheter  | 3 (7.9)          | 1 (10) | Fisher >0.05 (NS) |
| Age       | 71 ± 6           | 70 ± 5 | 1.1 | >0.05 (NS) |
| Duration  | 32 ± 17          | 30 ± 22 | 0.8 | >0.05 (NS) |

The higher frequency of CVA and mortality in the assisted group compared with the normal group, with statistically significant difference, as assessed with the Fisher exact test. CAD, coronary artery disease; CVA, cerebrovascular accident; PVD, peripheral vascular disease; S, significant. *Unpaired t-test. *Mann–Whitney test.

The incidence of stroke is much higher in CKD patients than in the general population. The United States Renal Data System (USRDS) and National Inpatient Sample (NIS) studies reported by Dialysis Outcome and Practice Patterns Study (DOPPS) consistently show a marked difference in crude mortality between different countries, with mortality in the USA being one of the highest. For example, in 2003, DOPPS reported the crude 1-year mortality rate to be 6.6% in Japan, 15.6% in Europe, and 21.7% in the USA [12]. In DOPPS III, 8161 in-center hemodialysis patients participated; the median follow-up was 18 months. During the study period, 1337 participants died (crude mortality rate for all study participants was 12.2/100 patient-years, with mortality rates of 3.7, 10.4, and 21.4 deaths per 100 patient-years for patients <45, 45–74, and ≥75 years of age, respectively) [13].
Hospital Discharge Survey (NHDS) data sets show that the incident dialysis population suffers from a 5–10-fold higher risk of hospitalized stroke in comparison with the non-CKD population [14]. The short-term and long-term mortality associated with stroke appears to be higher in CKD patients than in the general population. In the Okinawa Dialysis Study (OKIDS), the 30-day stroke mortality rate was higher in CKD patients compared with the rate observed in the general population in Okinawa, Japan [15]. In a recent study from Taiwan, among 5672 maintenance hemodialysis patients, 650 (11.5%) patients had prior stroke and were found to have a 36% increased risk for mortality compared with those without prior stroke (HR 1.36, 95% CI 1.22–1.52) [16].

Cognitive disorders have long been recognized as a complication of CKD5 and its treatment. The prevalence of cognitive impairment, as assessed using neuropsychological tests among patients with CKD5, ranges from 16 to 38% depending on the sample and the definition of impairment [17]. Dementia increases the risk for poor outcomes, including disability, hospitalization, withdrawal from dialysis, and death [18–20].

To emphasize the importance of mobility and autonomy in dialysis patients, McAdams-DeMarco et al. [21] enrolled 146 incident hemodialysis patients and followed them up for around 30 months. They found that adults of all ages undergoing hemodialysis have a high prevalence of frailty, more than five times as high as community-dwelling older adults. In this population, regardless of age, frailty is a strong, independent predictor of mortality and number of hospitalizations [21].

In a French study, Couchoud et al. [22] established and validated a bedside scoring system for predicting 6-month mortality in elderly hemodialysis patients. Dependency for transfer was given the highest score of 3 points, compared with diabetes, which was given only 1 point [22].

Vascular access is an important predictor of death in hemodialysis patients. The relative risk for death is increased 2–3-fold in incident patients using catheters compared with those using an arteriovenous access (fistula or graft) [23].

In our study, vascular access had no significant survival outcome. This may be explained by the small number of patients with a catheter (4/48 patients, 8.3%).

For elderly individuals who progress to CKD5, hemodialysis is often a valuable treatment option. Although hemodialysis is a life-sustaining therapy and extends life, it may also create, increase, or prolong suffering in selected subgroups of geriatric patients. In fact, hemodialysis has the attributes of a serious and progressive chronic illness; it may correct uremia, but the disease pathway of the elderly continues [24,25]. In our studied cohort of patients, there was significant association between both CAD and PVD and cognitive function impairment. This may be because both stem from a common pathological pathway, atherosclerosis, which is well established and has its unique traditional and nontraditional risk factors in CKD patients, especially when diabetes is the etiology of CKD. Moreover, dialysis itself is associated with a significantly increased risk for worsening vascular disease. Registry data and data from observational cohort studies suggest that coexisting vascular disease, whether CAD, PVD, or cerebrovascular disease, is associated with increased mortality risk for patients on dialysis [26,27].

In conclusion, our study showed a mortality rate of 7.5% in elderly diabetic patients above 65 years. The mortality in such a high-risk group was significantly associated with CVA, cognitive impairment, and lost autonomy.

The limitations of our study include its retrospective nature and the limited number of patients. Nephrologists require more data on renal replacement options in the elderly, as well as on outcome from different options. From this point of view our study might be useful but definitely we are awaiting large-scale studies better characterizing this heterogeneous risky group as well as guidelines for treatment options and outcome.

Acknowledgements
The authors thank the dialysis unit team, medical records department, and research committee at Dr Erfan and Bagedo General Hospital, Jeddah, Saudi Arabia, for their help and support during the preparation of this study.

Conflicts of interest
There are no conflicts of interest.

References
1 Nakai S, Suzuki K, Masakane I, et al. Overview of regular dialysis treatment in Japan (as of 31 December 2008). Ther Apher Dial 2010; 14:505–40.
2 Jager KJ, van Dijk PC, Dekker FW, Stengel B, Simpson K. Briggs JDERA-EDTA registry committee. The epidemic of aging in renal replacement therapy: an update on elderly patients and their outcomes. Clin Nephrol 2003; 60:352–60.
3 ERA-ADTA Registry. ERA-EDTA registry 2005 annual report. Amsterdam, the Netherlands: Department of Medical Informatics, Academic Medical Center, 2007.
Outcomes of hemodialysis in elderly diabetic patients

Carson RC, Juszczak M, Davenport A, Burns A. Is maximum conservative management an equivalent treatment option to dialysis for elderly patients with significant comorbid disease? Clin J Am Soc Nephrol 2009; 4: 1611–9.

Burns A, Davenport A. Maximum conservative management for patients with chronic kidney disease stage 5. Hemodial Int 2010; Suppl 1:S32–7.

Miller MC, Knapp RG. Clinical epidemiology and biostatistics. 3rd ed. Maryland: Williams & Wilkins; 1992.

Thane P. History and the sociology of ageing. Soc Hist Med 1989; 2: 93–96.

Glascock AP, Feirman SL. A holocultural analysis of old age. Comp Soc Res 1980; 3:311–32.

Freund AM, Smith J. Self-definition in old age. Z Sozialpsychol 1997; 28:44–59

Kurella M, Covinsky KE, Collins AJ, Chertow GM. Octogenarians and nonagenarians starting dialysis in the United States. Ann Intern Med 2007; 146:177–83.

US Renal Data Systems. USRDS 2005 Annual Data Report. Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2005.

Goodkin DA, Bragg-Gresham JL, Koenig KG, Wolfe RA, Akiba T, Andreucci VE, et al. Association of comorbid conditions and mortality in hemodialysis patients in Europe, Japan, and the United States: the Dialysis Outcomes and Practice Patterns Study (DOPPS). J Am Soc Nephrol 2003; 14:3270–7.

Canaud B, Tong L, Tentori F, Akiba T, Karaboyas A, Gillespie B, et al. Clinical practices and outcomes in elderly hemodialysis patients: results from the Dialysis Outcomes and Practice Patterns Study (DOPPS). Clin J Am Soc Nephrol 2011; 6:1651–62.

Seliger SL, Gillen DL, Tirschwell D, Wasse H, Kestenbaum BR, Stehman-Breen CO. Risk factors for incident stroke among patients with end-stage renal disease. J Am Soc Nephrol 2003; 14:2623–31.

Iseki K, Tozawa M, Iseki C, Takishita S, Ogawa Y. Demographic trends in the Okinawa Dialysis Study (OKIDS) registry (1971–2000). Kidney Int 2002; 61:668–75.

Chien CC, Sun YM, Wang JJ, Chu CC, Lu CL, Wang SF, et al. Increased risk of mortality among haemodialysis patients with or without prior stroke: a nationwide population-based study in Taiwan. Indian J Med Res 2013; 138:232–8.

Kurella Tamura M, Larive B, Unruh M, et al. Prevalence and correlates of cognitive impairment in the frequent hemodialysis network (FHN) trials. Clin J Am Soc Nephrol 2010; 8:1429–1438.

Kurella M, Mapes DL, Port FK, Chertow GM. Correlates and outcomes of dementia among dialysis patients: the Dialysis Outcomes and Practice Patterns Study. Nephrol Dial Transplant 2006; 21:2543–8.

Kurella Tamura M, Covinsky KE, Chertow GM, Yaffe K, Landefeld CS, McCulloch CE. Functional status of elderly adults before and after initiation of dialysis. N Engl J Med 2009; 361:1539–47.

Rakovski DA, Caillard S, Agoda LY, Abbott KC. Dementia as a predictor of mortality in dialysis patients. Clin J Am Soc Nephrol 2006; 1:1000–5.

McAdam DeMarco MA, Law A, Salter ML, Boyarsky B, Gimenez L, Jaar BG, et al. Frailty as a novel predictor of mortality and hospitalization in individuals of all ages undergoing hemodialysis. J Am Geriatr Soc 2013;61:996–901.

Couchoud C, Labeeuw M, Moranne O, Allot V, Einaudi V, Frimat L, Stengel B. French Renal Epidemiology and Information Network (REIN) registry. A clinical score to predict 6-month prognosis in elderly patients starting dialysis for end-stage renal. Nephrol Dial Transplant 2009; 24:1553–61.

Polkinghorne KR, McDonald SP, Atkins RC, Kerr PG. Vascular access and all-cause mortality: a propensity score analysis. J Am Soc Nephrol 2004; 15:477–86.

Swidler M. Dialysis decisions in the elderly patient with advanced CKD and the role of nondialytic therapy (Chapter 37). In: Oreopoulos D, Wiggins J, editors American Society of Nephrology Geriatric Nephrology Curriculum. Washington, DC, USA: American Society of Nephrology; 2009. 1–7.

Wong CF, McCarthy M, Howse ML, Williams PS. Factors affecting survival in advanced chronic kidney disease patients who choose not to receive dialysis. Ren Fail 2007; 29:653–659.

Foley RN, Parfrey PS, Samak MJ. Clinical epidemiology of cardiovascular disease in chronic renal disease. Am J Kidney Dis 1998; 32(Suppl 3): 112–9.

Levin A, Djurdjev O, Barrett B, Burgess E, Carlisle E, Ether J, et al. Cardiovascular disease in patients with chronic kidney disease: getting to the heart of the matter. Am J Kidney Dis 2001; 38:1398–407.