SAPD: Sürekli Ayaktan Periton Diyalizi

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YENİ DİYALİZE BAŞLAYACAK SON DÖNEM BÖBREK YETMEZLİKLİ HASTALARDA ÖNERİLEN TEDAVİ STRATEJİSİ

Nefroloji merkezine hastaların erken gönderilmesi

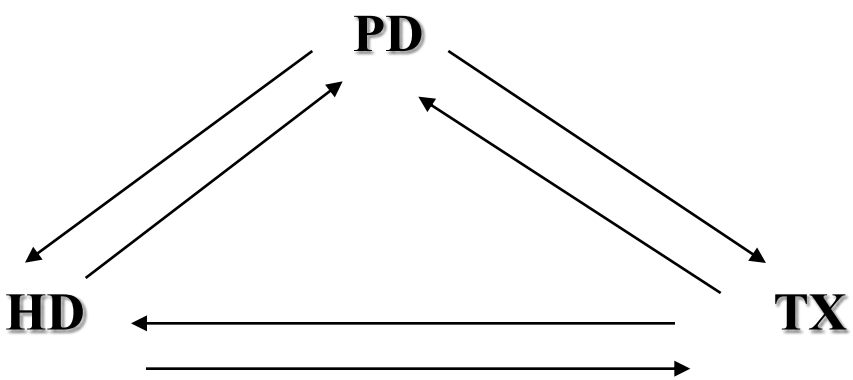
↓

Hasta eğitimi

↓

Hasta eğer uygun ve istekli ise periton diyalizinin önerilmesi

↓



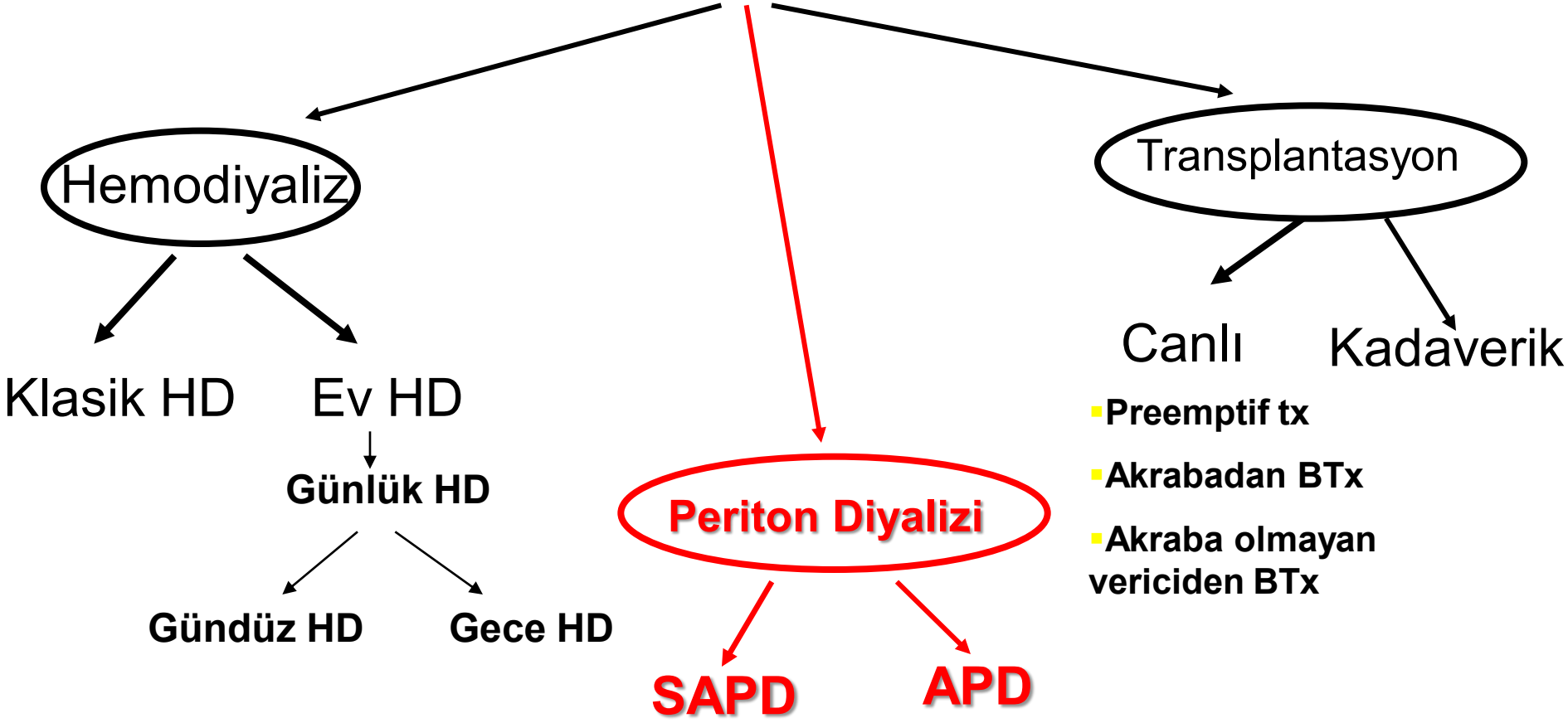
Coles GA,William JD, Kidney Int 1998

Periton Diyalizinin SDBY Başlangıç Tedavisi olmasının avantajları

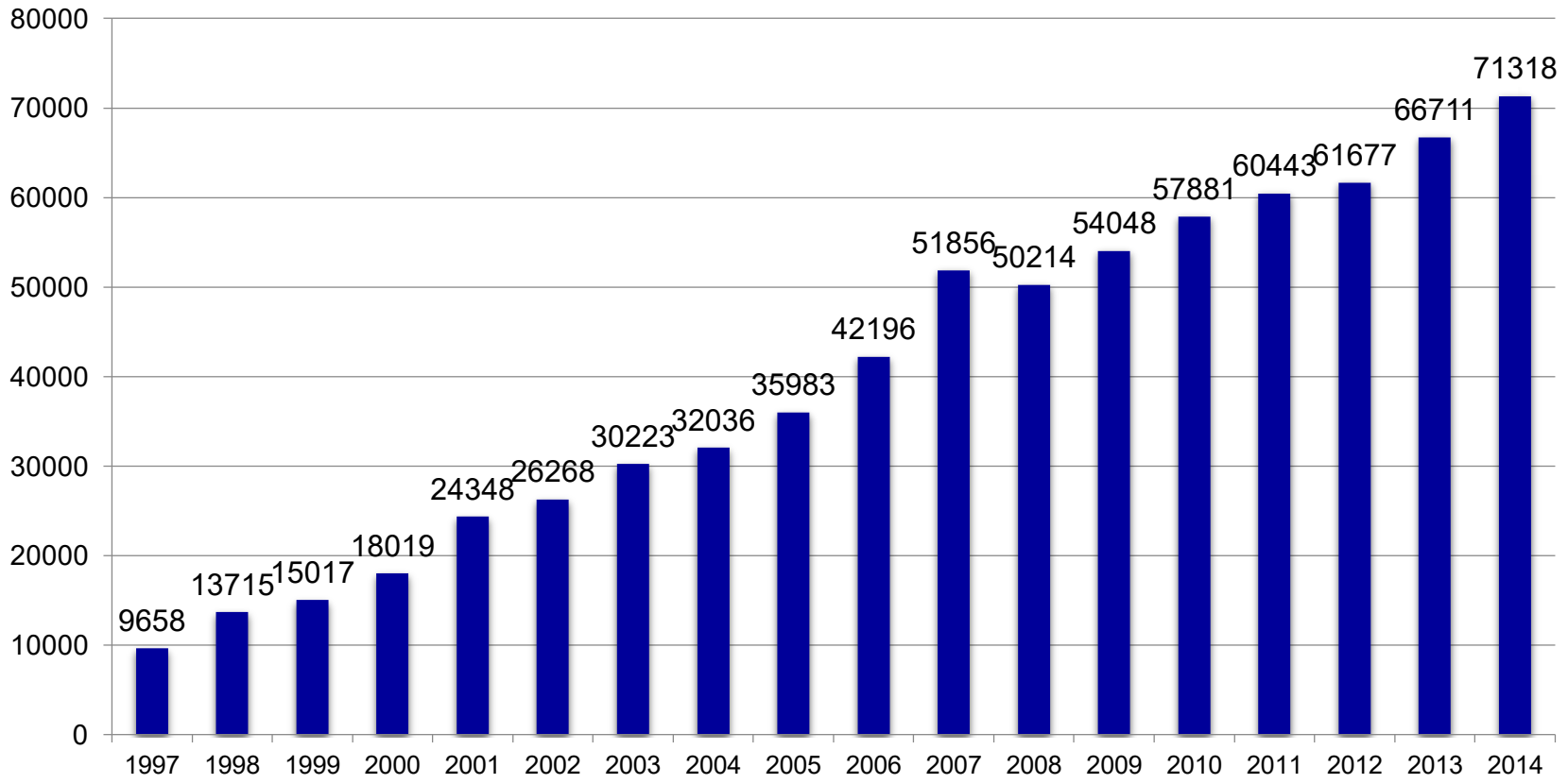
(Davies. Integrated care. PDI 2001)

- Residüel renal fonksiyonun daha uzun süre korunabilmesi
- Vasküler erişim bölgelerinin korunabilmesi
- Kanla bulaşan hastalıklara karşı korunabilme avantajı
- Maliyet ve lojistik avantajlar
- Daha yüksek yaşam kalitesi
- Renal transplantasyon sonrası erken graft yetersizliğinin daha az görülmesi.

Renal Replasman Tedavisi (=Böbrek yerine koyma tedavisi)

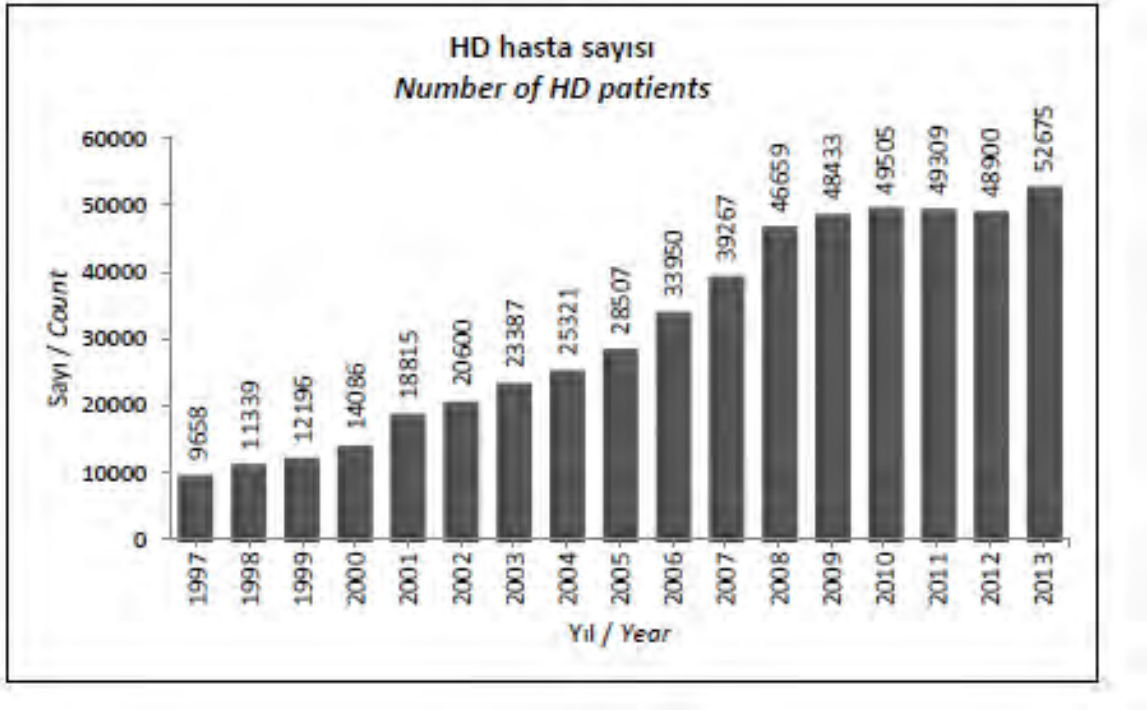


Türkiye'de RRT Hasta Sayıları



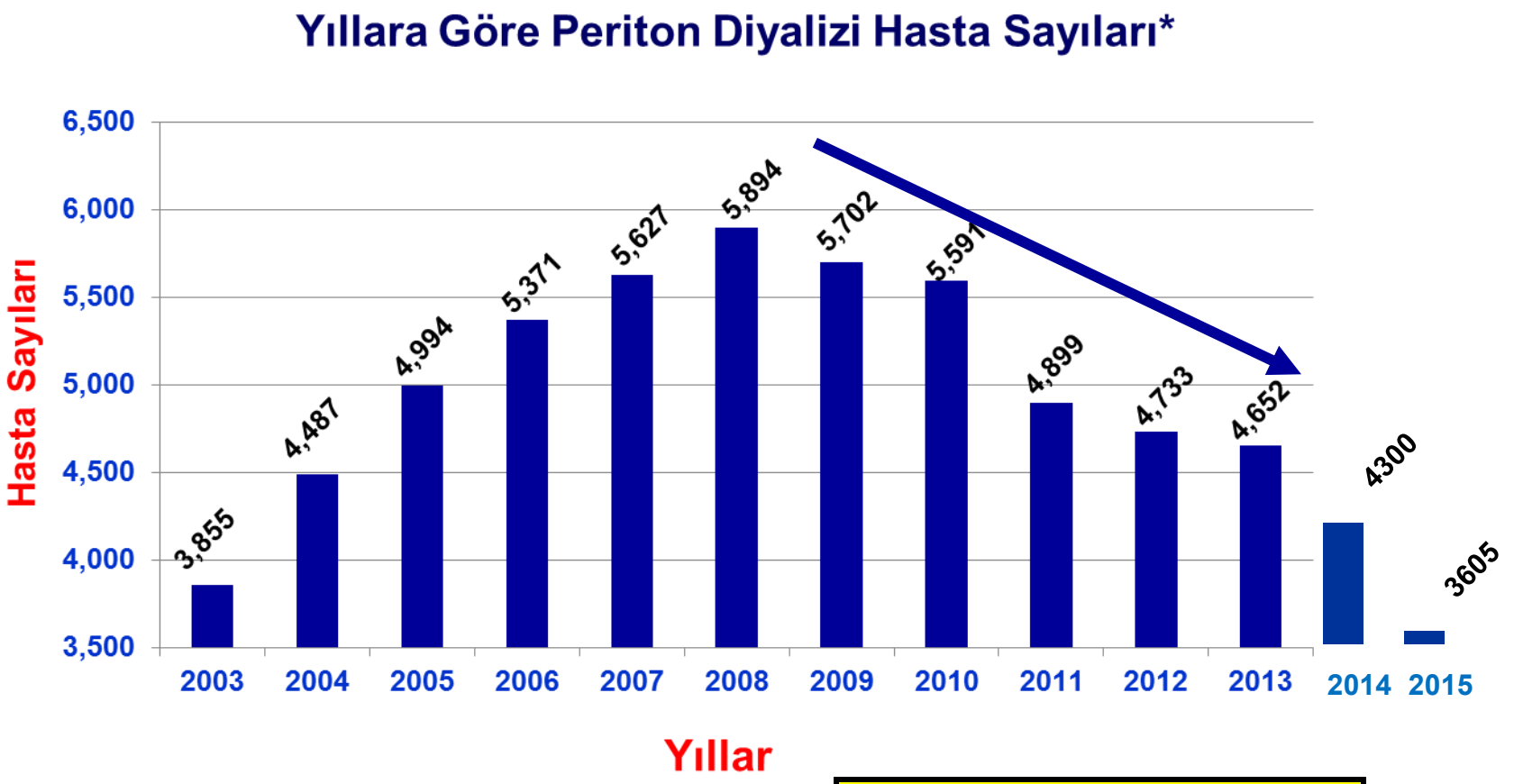
TND Böbrek Kayıt Sistemi Verileri

Türkiye’de HD tercihi: Yıllara göre.



Registry 2013 (TND-T.C. Sağlık Bakanlığı)

Türkiye'de PD tercihi: Yıllara göre.



*:T.C. Sağlık Bakanlığı Verileri

2014: 4300 hasta.
2015: 3506 hasta.
Düşüş devam etmekte!

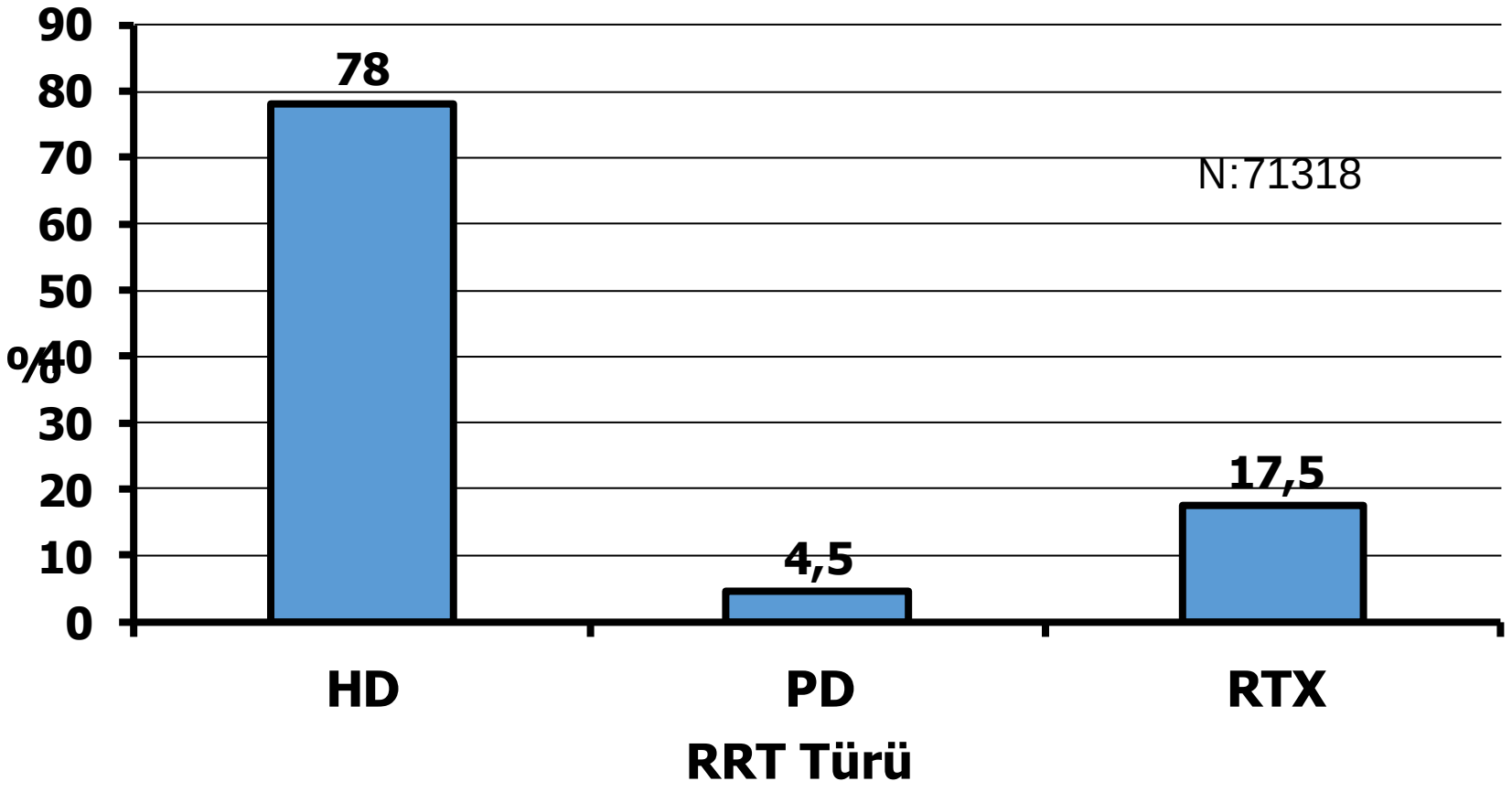
RRT Gören Prevalan SDBH Sayıları

RRT Modalitesi	Merkez Sayısı	Hasta Sayıları (%)	
Hemodiyaliz	849	60,315 (78)	**63,815**
Periton diyalizi	117	3,506 (4,5)	
Transplantasyon	75	~13,500 (17,5)	
Toplam		~77,315 (100)	

* SB Organ, Doku Nakli ve Diyaliz Hizmetleri Daire Başkanlığı

Türkiye' de RRT Oranları

(2015 Ekim İtibariyle)



* SB Organ, Doku Nakli ve Diyaliz Hizmetleri Daire Başkanlığı

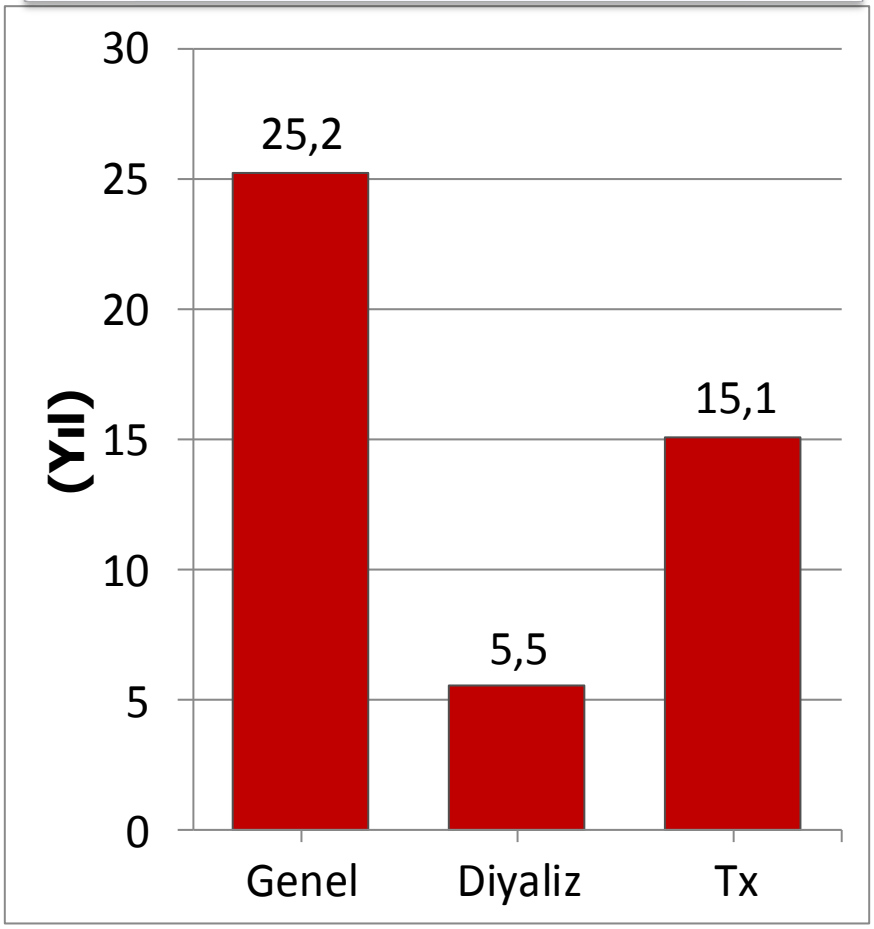
Buna rağmen Türkiye Dünya'da en çok PD hastasına sahip 9. ülkedir.

NUMBER OF PREVALENT PD PATIENTS WORLDWIDE (2013)		
1	MEXICO	41089
2	USA	26517
3	CHINA	16000
4	BRAZIL	9226
5	JAPAN	9157
6	INDIA	6500
7	COLOMBIA	6478
8	TAIWAN	4952
9	**TURKEY**	**4537**
10	UK	4190
11	CANADA	3989

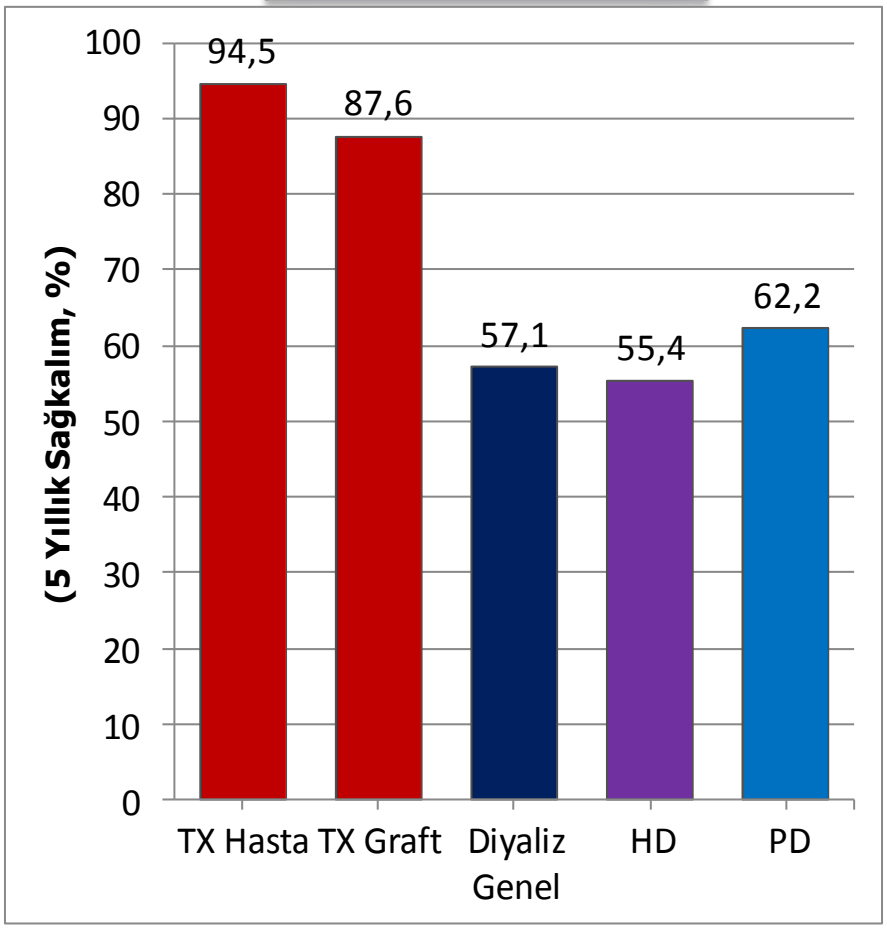
RRT’lerinde sağkalım beklentileri

Dünya'da Renal Replasman Tedavilerinde Sağkalım

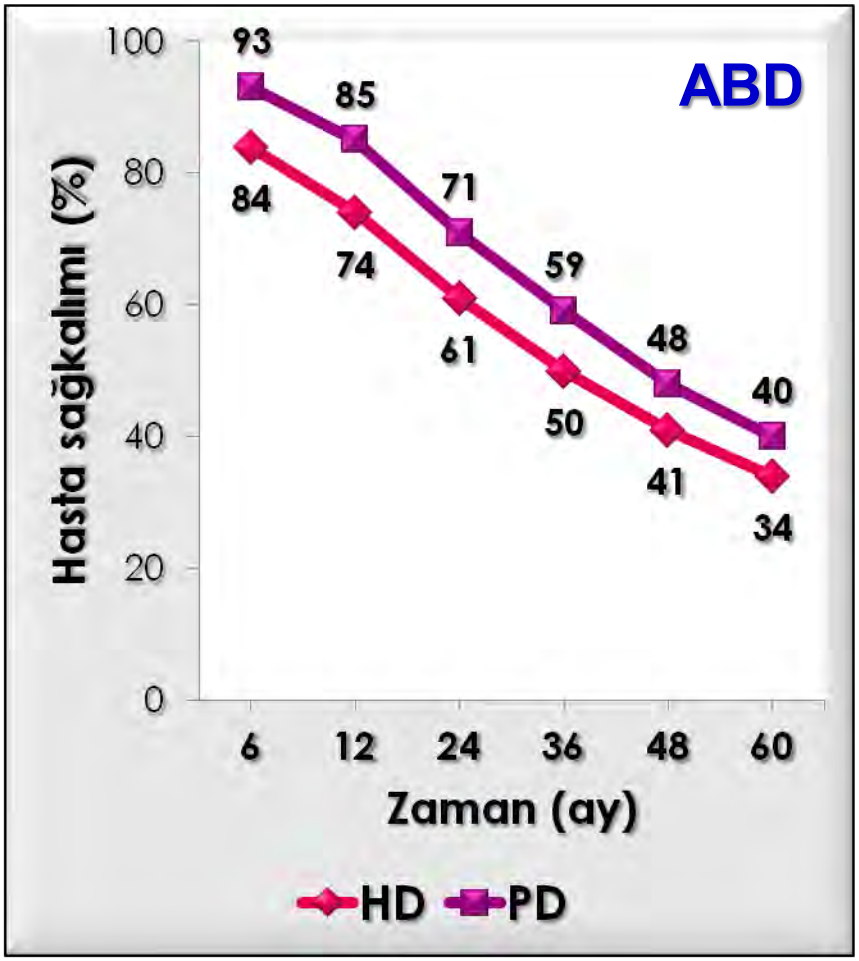
YAŞAM BEKLENTİSİ

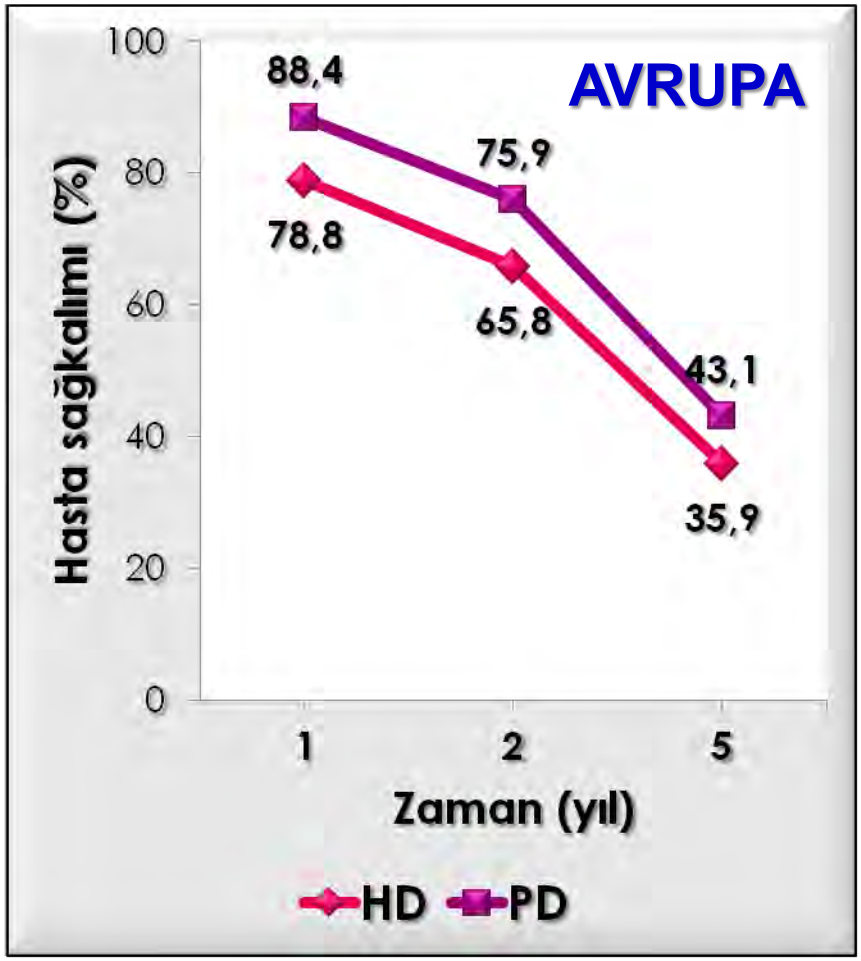


SAĞKALIM



ABD ve Avrupa'da Renal Replasman Tedavilerinde Sağkalım:





USRDS 2011 Raporu

Kramer A, et al. Nephrol Dial Transplant 2009;24:3557-66

Philip Kam-tao Li et al. Peritoneal Dialysis–First Policy Made Successful: Perspectives and Actions, *Am J Kidney Dis. 62(5):993-1005.2013*

Table 1. Mortality Comparison of Incident Adult Dialysis Patients Treated With PD and Hemodialysis

Study	Population	Impact on Patient Survival	Subgroup Analysis	Remarks	
Fenton et al[4] (1997)	11,970 CORR patients (1990-1994)	Significantly lower mortality for PD (aHR, 0.73; 95% CI, 0.68-0.78)	Survival advantage from PD first 2 y only; lower survival advantage for patients aged >65 y or diabetic	—	PD de daha iyi sağkalım
Heaf et al[5] (2002)	4,921 DSN TUR patients (1990-1999)	Significantly lower mortality for PD (aRR, 0.65; 95% CI, 0.59-0.72)	Survival advantage from PD first 2 y only	—	PD de daha iyi sağkalım
Jaar et al[6] (2005)	1,041 CHOICE Study patients (1995-1998)	No difference in mortality (aHR, 1.39; 95% CI, 0.64-3.06) for PD in first y; significantly higher risk (aHR, 2.34; 95% CI, 1.19-4.59) for PD in second y	No survival difference in patients with better case-mix profile and the highest propensity for initially receiving PD	Patients enrolled a median of 45 d after starting dialysis[a]	Fark yok
Liem et al[7] (2007)	16,643 RENINE patients (1987-2002)	Significantly lower mortality for PD (HR, 0.70; 95% CI, 0.67-0.74)	Relative survival advantage for PD decreases with time	Patients excluded if death occurred in first 90 d of dialysis[b]	PD de daha iyi sağkalım
Huang et al[8] (2008)	48,629 Taiwan Renal Registry patients (1995-2002)	No significant difference in survival; lower mortality ratio for PD patients aged <55 y and nondiabetic	—	Patients excluded if death occurred in first 90 d of dialysis[b]	Fark yok
Sanabria et al[9] (2008)	923 DOC Study patients (2001-2003)	Non–statistically significantly lower mortality rate for PD (aHR, 0.81; 95% CI, 0.64-1.02)	Lower mortality risk for young nondiabetic patients treated with PD	—	PD de daha iyi sağkalım
McDonald et al[10] (2009)	25,287 ANZDATA patients (1991-2005)	Significantly lower mortality rates during first y for PD (aHR, 0.89; 95% CI, 0.81-0.99)	PD associated with lower mortality during first 90 d; higher survival benefit of PD in patients aged <60 y without comorbid conditions	Patients excluded[c] if death occurred in first 90 d of dialysis[b]	PD de daha iyi sağkalım

Philip Kam-tao Li et al. Peritoneal Dialysis–First Policy Made Successful: Perspectives and Actions, *Am J Kidney Dis. 62(5):993-1005.2013*

Weinhandl et al[11] (2010)	12,674 CMS Medical Evidence Report patients[d] (2003)	Significantly lower mortality for PD (HR, 0.92; 95% CI, 0.86-1.00)	Similar adjusted 4-y survival	Propensity matching; patient outcomes analyzed from d 0 and secondary analysis of survival from d 90	PD de daha iyi sağkalım
Mehrotra et al[12] (2011)	684,426 USRDS patients (1996-2004)	Secular trend: progressive attenuation in the higher mortality risk for PD; in 2002-2004 cohort, no significant difference in mortality risk over 5 y for PD (aHR, 1.03; 95% CI, 0.99-1.06)	Relatively greater improvement of survival on PD over time	Patient excluded[c] if death occurred during the first 90 d of dialysis; largest sample size	Fark yok
Perl et al[13] (2011)	38,512 CORR patients (2001-2008)	Significantly higher 1-y mortality for HD patients who started with CVC (aHR, 1.8; 95% CI, 1.6-1.9); no significant difference in 1-y mortality between PD and HD patients who started with AVF or AVG (aHR, 0.9; 95% CI, 0.8-1.1)	Small survival benefit in HD patients with AVF or AVG after 1 y of dialysis	Multivariable piece-wise exponential nonproportional and proportional hazards models	Fark yok
Quinn et al[15] (2011)	6,573 Ontario patients (1998-2006)	No significant difference in survival between PD and HD patients (aHR, 0.96; 95% CI, 0.88-1.06)	Higher mortality rate for diabetic patients on PD	All participants received ≥4 mo of predialysis care and started dialysis electively as outpatients	Fark yok

Philip Kam-tao Li et al. Peritoneal Dialysis–First Policy Made Successful: Perspectives and Actions, *Am J Kidney Dis. 62(5):993-1005.2013*

Table 1 (Cont'd). Mortality Comparison of Incident Adult Dialysis Patients Treated With PD and Hemodialysis

Study	Population	Impact on Patient Survival	Subgroup Analysis	Remarks
Chang et al[16] (2012)	9,442 Taiwan National Health Insurance claims data patients (1997-2006)	Secular trend: decline in HR for PD; in 2002-2006 cohort, no significant difference in mortality risk for PD (aHR 0.99; 95% CI, 0.87-1.14)	Lower mortality risk for young nondiabetic patients on PD	Propensity matching
Yeates et al[17] (2012)	46,839 CORR patients (1991-2007)	Overall survival favored PD in first 18 mo and HD after 36 mo; secular trend: survival favored PD for first 2 y for 2001-2004 cohort, similar between PD and HD after 2 y	Higher mortality risk for female patients aged >65 y with diabetes	Patients excluded[c] if death occurred during first 90 d of dialysis

Fark yok

ilk 2 yıl PD daha iyi
2 yıldan sonra eşit

Türkiye'de HD hastalarında mortalite: 55890 hasta (2014)

Yaş / *Age*	Erkek / *Male*		Kadın / *Female*		Toplam / *Total*	
	n	%	n	%	n	%
0-19	6	0.09	6	0.09	12	0.18
20-44	261	3.75	194	2.79	455	6.54
45-64	1028	14.78	709	10.19	1737	24.97
65-74	1158	16.65	990	14.23	2148	30.88
≥75	1303	18.73	1300	18.69	2603	37.43
Toplam / *Total*	3756	54.00	3199	46.00	6955	100.00

Ölüm hızı: 6955/55890**=%12**

Türkiye'de PD hastalarında mortalite: 3567 hasta.(2014)

	Erkek / *Male*		Kadın / *Female*		Toplam / *Total*	
Yaş / *Age*	**n**	**%**	**n**	**%**	**n**	**%**
0-19	7	2.26	5	1.61	12	3.87
20-44	9	2.90	13	4.19	22	7.10
45-64	63	20.32	49	15.81	112	36.13
65-74	57	18.39	41	13.22	98	31.61
≥75	29	9.35	37	11.94	66	21.29
Toplam / *Total*	165	53.23	145	46.77	310	100.00

Ölüm hızı: 165/3567**=%5**

TND Registry 2014

Türkiye'den bir çalışma:
Yaşlı PD hastalarında klinik sonuçlar ve mortalite

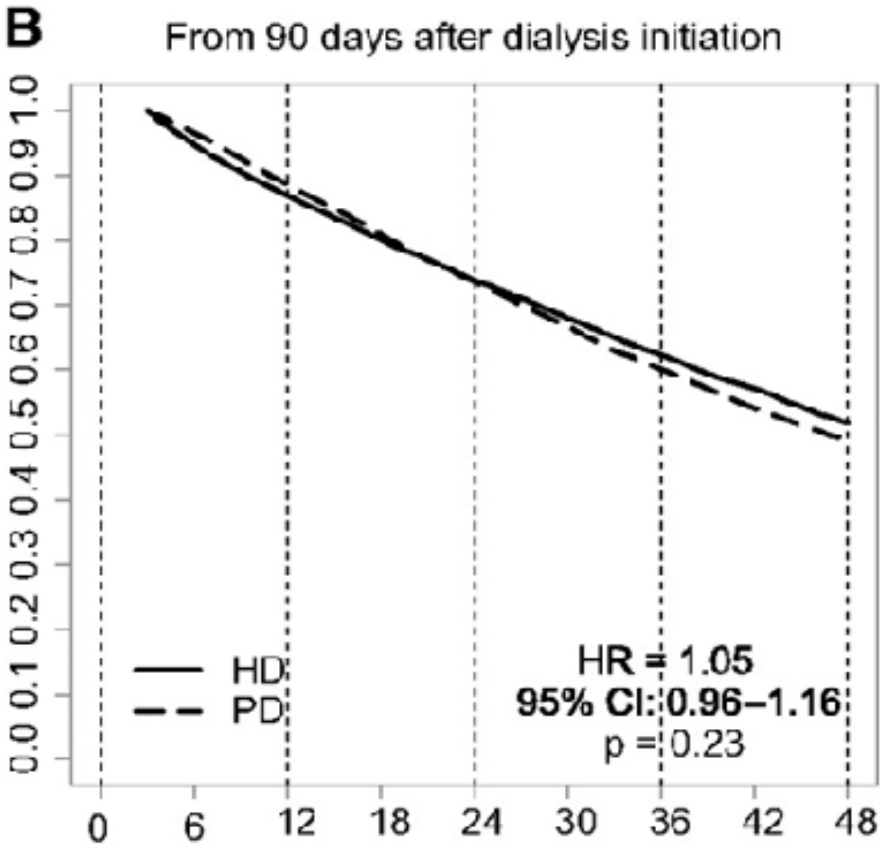
Table 3 - Final status of the patients.

Cause	%
Death (n:30)	
Sepsis/peritonitis (n:15)	50
Cardiovascular events (n:9)	30
Malnutrition/PD insufficiency (n:3)	10
Unknown (n:3)	10

Clinical outcomes and mortality in elderly peritoneal dialysis patients Tamer Sakacı, Elbis Ahbap, Yener Koc[*] , Taner Basturk, Zuhal Atan Ucar, Ayse Sınangıl, Mustafa Sevınc, Ekrem Kara, Cuneyt Akgol, Arzu Ozdemır Kayalar, Feyza Bayraktar Caglayan, Tuncay Sahutoglu, Abdulkadir Ünsal ***Clinics vol.70 no.5 São Paulo May 2015***

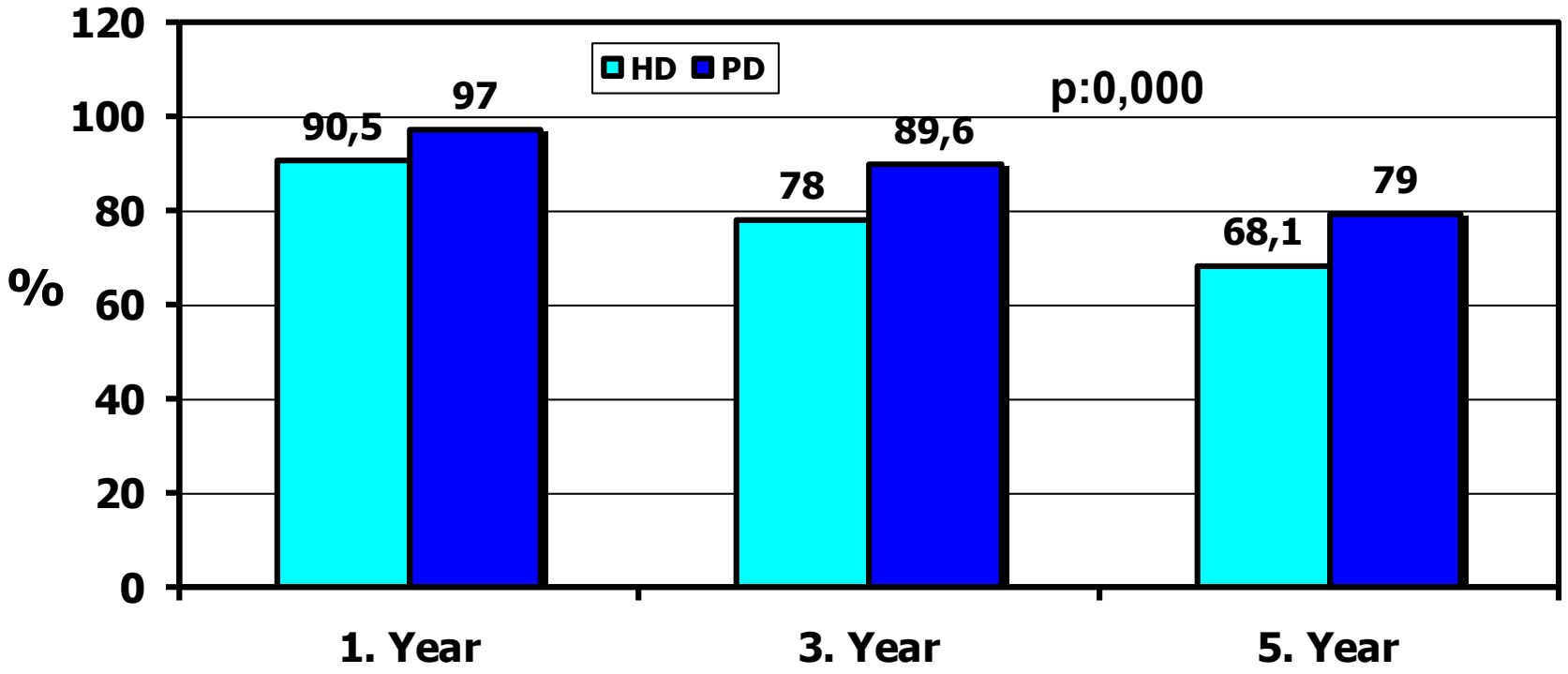
2010’da PD’de HD’e göre %8 daha düşük mortalite!

- 6.337 PD hastasına, 92.187 HD hastası arasından uyumlu-benzer 6.337 hasta seçiliyor
- PD ile toplamda-genelde %8 daha düşük mortalite



Weinhandl ED et al. J Am Soc Nephrol 2010; 21: 499

2010:Türkiye'de de PD'de daha uzun yaşam beklentisi!



TND Hasta Kayıt Verileri 2010

Türkiye'de PD hastalarında mortalite nedenleri

	n	%
Kardiyovasküler / *Cardiovascular*	56	40.29
İnfeksiyon / *Infection*	28	20.14
Serebrovasküler / *Cerebrovascular*	12	8.63
Malignite / *Malignancy*	11	7.91
Akciğer yetmezliği / *Pulmonary failure*	4	2.88
Karaciğer yetmezliği / *Hepatic failure*	2	1.44
Gastrointestinal kanama / *Gastrointestinal bleeding*	1	0.72
Diğer / *Other*	25	17.99
Toplam / *Total*	139	100.00

TND Registry 2014

CAUSES OF PATIENT WITHDRAWAL FROM PERITONEAL DIALYSIS IN TURKEY

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(A TULIP- "Turkish [illegible] Study Group" study)

Purpose: Aims of this study were to clarify the reasons causing discontinuation of peritoneal dialysis (PD) in a large population of PD patients and to propose appropriate strategies that might help in prolonging the use of that modality as a renal replacement therapy.

Patients and Methods: We enrolled 14 centers with 811 prevalent patients in the study. Participating centers starting from 1 June 2013, have filled a detailed center specifications form at the beginning of the study period and in order to report details about each patient who have discontinued peritoneal dialysis treatment an additional patient drop-out form for 18-months study period.

Results: Mean duration of dialysis in 235 cases (female/male distribution 94/141) who have discontinued PD, was 54.6 months with a mean patient age of 59.2 (21-99) years. Etiological classification of those patients have revealed, hypertensive nephropathy: 26%; DM: 25%; glomerulonephritis: 6%; amyloidosis: 3%; polycystic disease: 6%; other interstitiel nephritis: 2% and unknown or other conditions (30%) as the primary cause of CKD. Out of 235 cases, 94 patients (40%) were transferred to HD, 83 (36%) have died, 39 patients (17%) were transplanted and 19(8%) were transferred to another center and was lost for follow up . The mean age of transplanted patients was younger (42.5 years) than the age of patients died on PD (65.9 years). 28 patients have been on PD for more than 10 years with no history of peritonitis in 4 of them. One of our patients have been on PD for 237 months (19.7 years) with again no history of peritonitis. Main reasons for discontinuation for PD were: peritonitis 44%, inadequate ultrafiltration (26%), catheter related problems (9%), EPS (3%) and others such as hernias, inappropriate PET results, patient exhaustion etc. (14%). In patients who have discontinued PD treatment due to inadequate ultrafiltration , salt restriction measures were practiced in only 68%. 7 patients have been diagnosed as EPS before the cessation of PD treatment. Those 7 patients had a mean dialysis time of 133 months (11 years).

Conclusion: In Turkey, which is a country with a declining PD prevalance of 4537 patients as of 2013 (Tables 2,3) (2), two main reasons for patient drop-out were peritonitis and inadequate ultrafiltration with a mean drop-out time of 54.6 months. Our results indicate that more effective and more strict salt restriction measures may be of benefit in patients with inadequate ultrafiltration as the primary cause for modality failure. Based on our findings, out of 28 patients who have been PD for more than 10 years, 7 patients (25%) have diagnosed as having EPS and that relatively high percentage was showing the importance of time factor in the pathogenesis of EPS.

References:
1- Jain A K et al. JASN 2012;23:533-544
2-Turkish Renal Registry 2013

TABLE 1: CAUSES FOR PATIENT WITHDRAWAL IN TURKEY

	CENTERS	Patient number	Drop out	Nurse number	Nurse/ Patient ratio	Reasons for DROP-OUT				
						Tx	HD	Death	Other causes	Peritonitis	EPS
1	Marmara U.	70	27	2	35	5	9	9	4	4	2
2	Bezmialem U.	18	11	1	18	2	5	4	0	2	0
3	T. Özal U.	117	33	2	59	12	4	16	1	1	0
4	S. Demirel U.	38	12	1	38	0	8	4	0	4	1
5	Nalbantoğlu EAH	27	12	2	14	0	5	7	0	2	0
6	İstanbul U.	40	9	2	20	4	4	1	0	1	0
7	Haseki EAH	48	7	2	24	1	2	4	0	1	0
8	Şişli Etfal EAH	59	8	2	30	1	6	1	0	2	2
9	Akdeniz U.	78	31	2	39	3	16	9	3	5	1
10	9 Eylül U.	38	20	1	38	3	10	1	6	3	0
11	Gazi U.	70	9	2	35	1	5	2	1	2	0
12	Erciyes U.	157	30	4	39	4	14	10	2	8	1
13	19 Mayıs U.	24	19	2	12	2	2	15	0	5	0
14	Selçuk U.	35	7	1	1	1	4	-	2	1	0
	Total	811	235			39 %1	94 %40	83 %36	19 %8	41 %17	7/% 3

TABLE 2: PD PATIENTS WORLDWIDE (1)

NUMBER OF PREVALENT PD PATIENTS WORLDWIDE		
1	MEXICO	41089
2	USA	26517
3	CHINA	16000
4	BRAZIL	9226
5	JAPAN	9157
6	INDIA	6500
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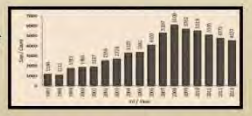
8	TAIWAN	4952
9	TURKEY	4537 (2)
10	UK	4190
11	CANADA	3989

TABLE 3: PD PATIENT PREVALENCE IN TURKEY (2)



CAUSES OF PATIENT WITHDRAWAL FROM PERITONEAL DIALYSIS IN TURKEY

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Semra Bozfakıoglu;
Turgay Arınsoy;
Abdülkadir Unsal;
Suleyman Turk;
Meltem Gürsu;
Rezzan Ataman
Kenan Ateş;

16th Congress of the International Society for Peritoneal Dialysis Melbourne, Australia; Saturday 27 February – Tuesday 1 March, 2016.

1-16 merkezli,905 hastalı,18 aylık prospektif gözlemsel çalışma
2-245 hasta tedavi dışı kalmış
3-88 hasta exitus

Ölüm hızı 6.84 /yıl
(HD ölüm hızı: %12/yıl)

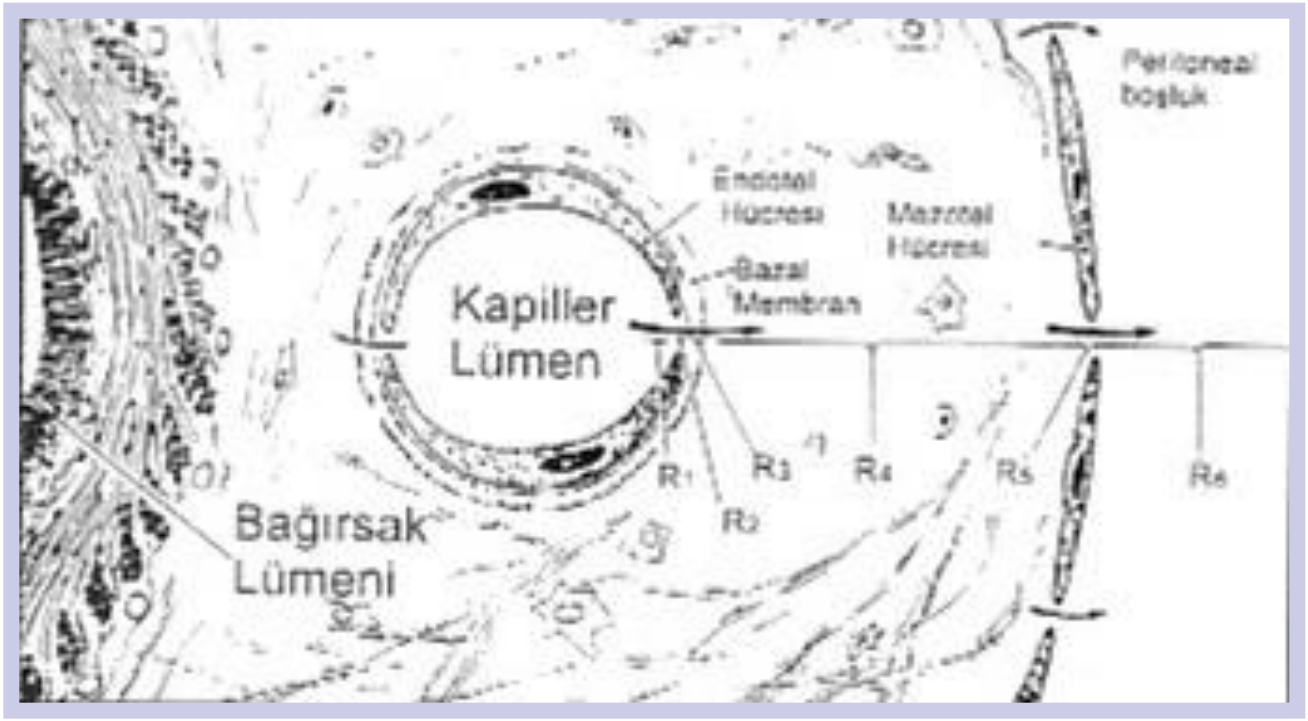
Kardiyovasküler ölümler:

- Koroner kalp hastalığı: %39
- Serebrovasküler olay: %10
- Emboli : %3
- Anevrizma rüptürü : %1=**%53**

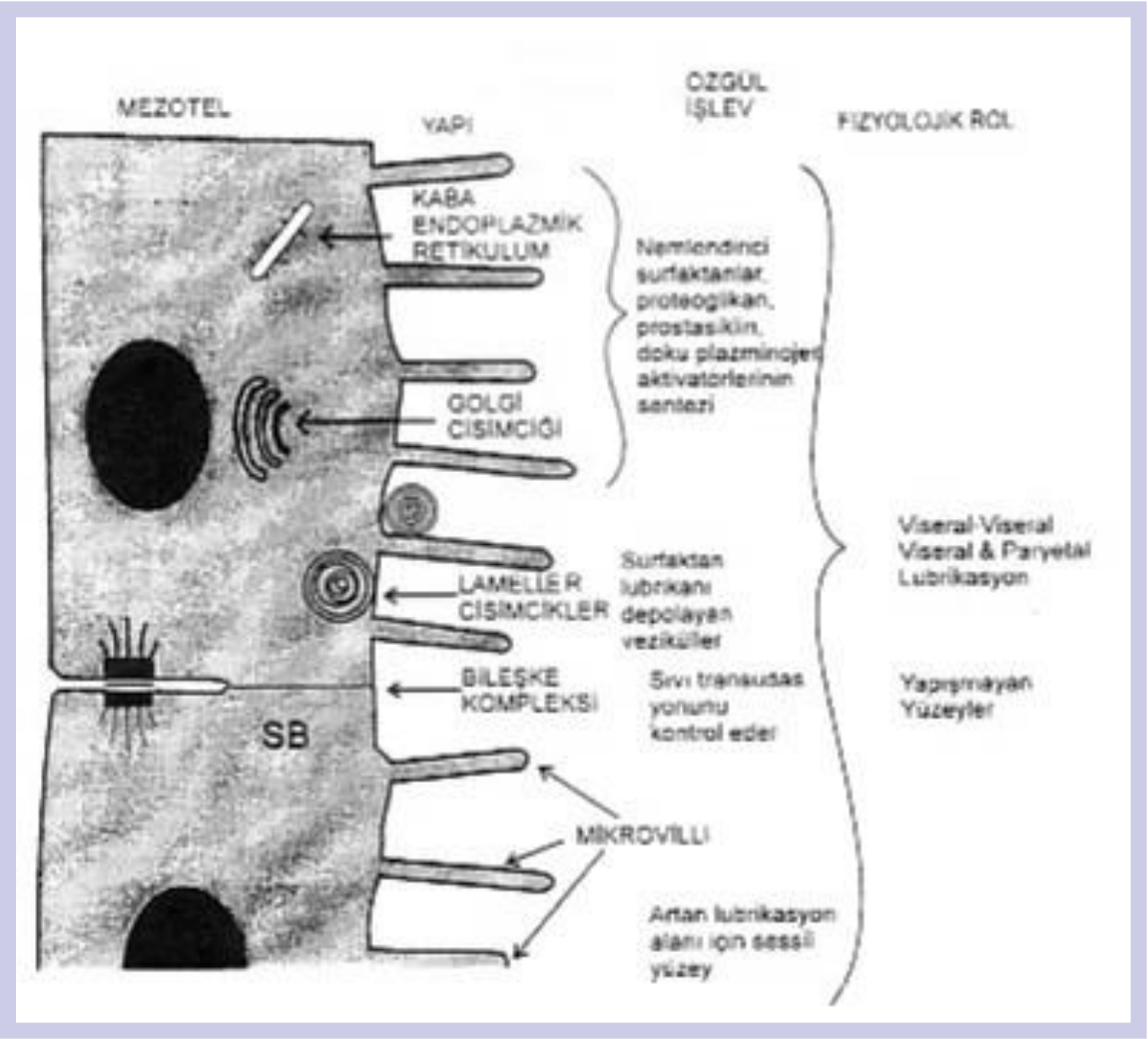
Periton diyalizi nedir?

PD’nin tarihçesi

- 1970 lerin ikinci yarısında ABD ve Kanada’da klinik uygulamalar pratiğe yaygın şekilde girmeye başladı
- Türkiye’de PD 1950 başlarında ABY’nde kliniklerde hazırlanan solüsyonlar ile uygulanmaya başlandı.
- 1980’li yıllarda ithal edilen solüsyonlar SAPD tedavisinde kullanıldı.
- SAPD solüsyonlarının 1995 yılında yerli üretimi ile uygulama hız kazandı.
- 1998’li yıllarda SAPD tedavisinin yanı sıra aletli periton diyalizi uygulaması başladı.

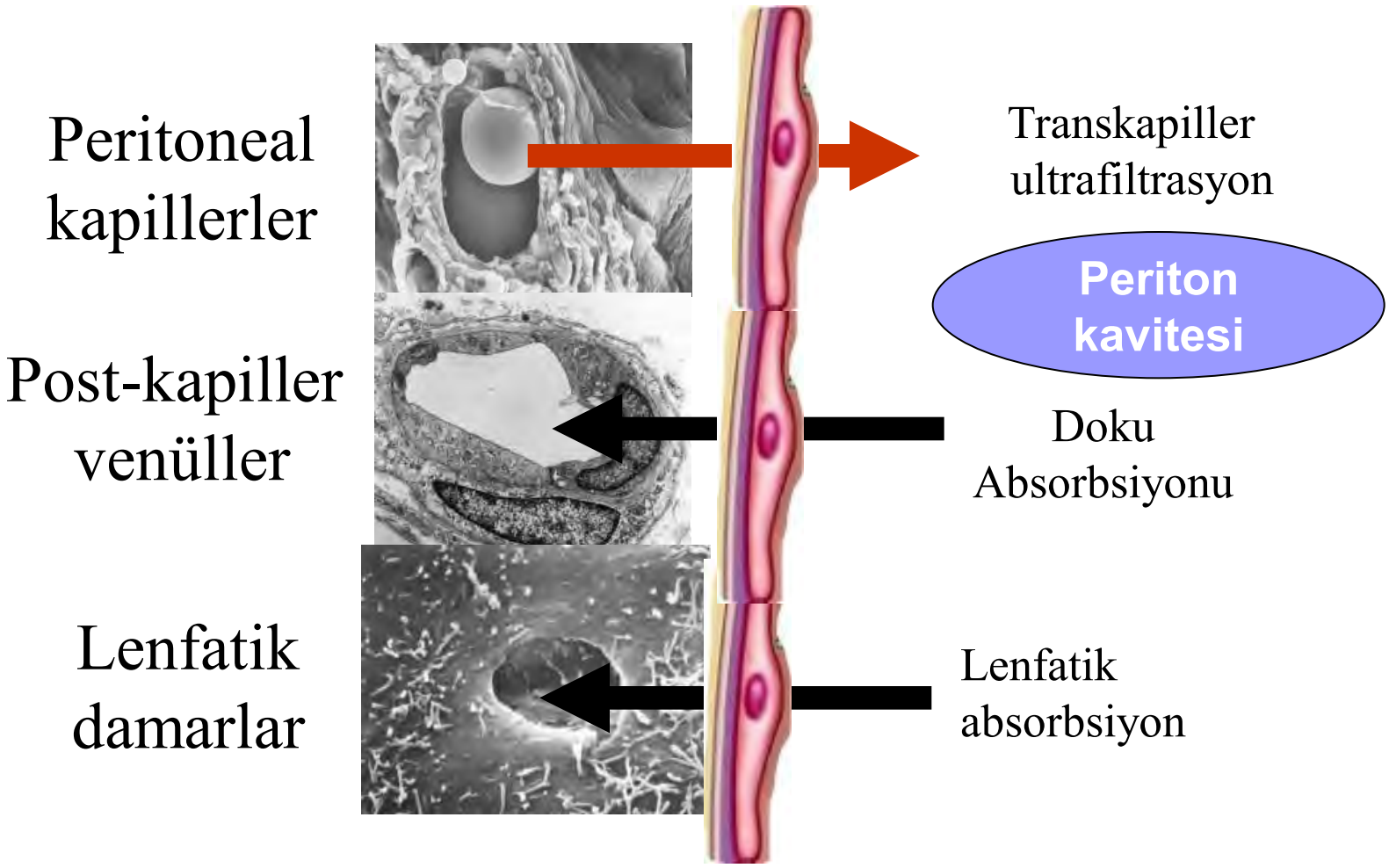


PERİTON, DİYALİZE UYGUN DOĞAL BİR MEMBRANDIR



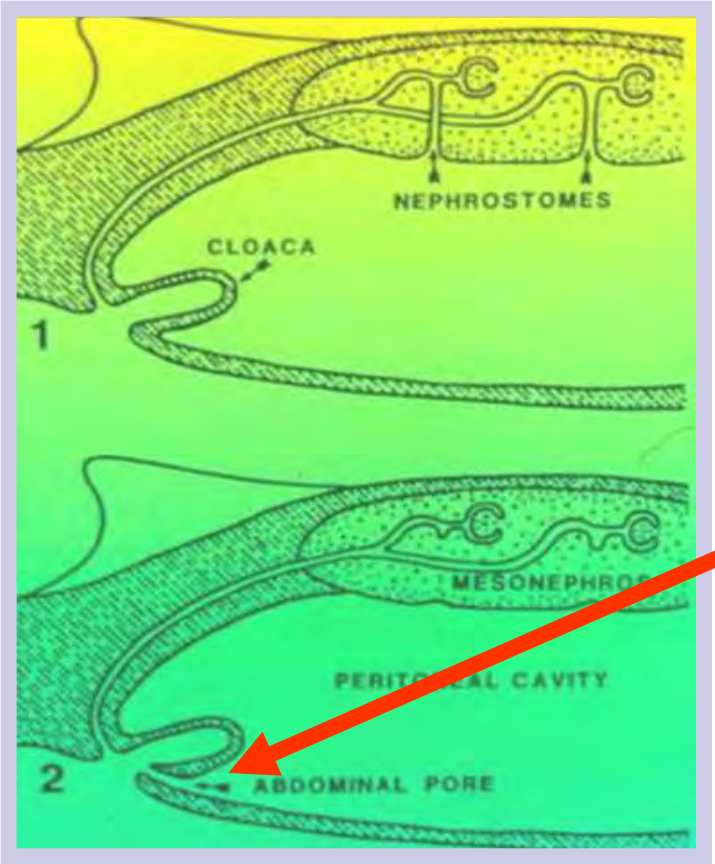
PERİTONUN TOPLAM YÜZEYİ BİR METREKARE KADARDIR

PD'de sıvı alışveriş mekanizmaları



TARİHİN İLK PD UYGULAMASI!

SOMON BALIĞI!



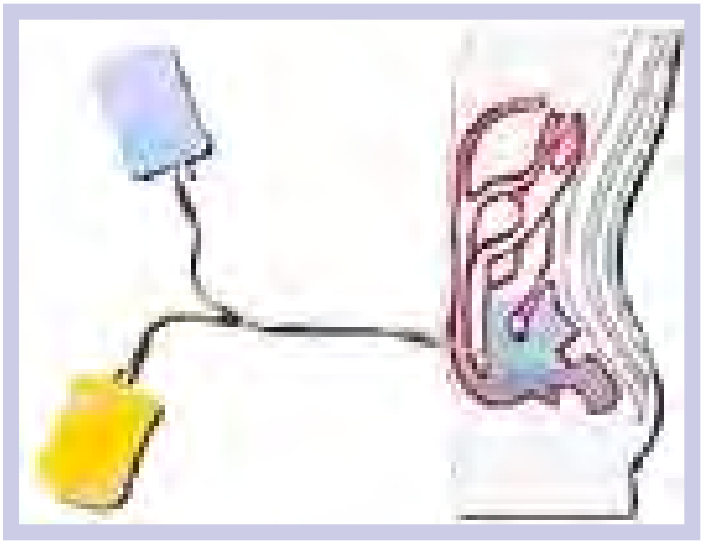
Somon balıklarında

Deniz suyu periton boşluğuna girer ve periton membranı böbreğe yardımcı

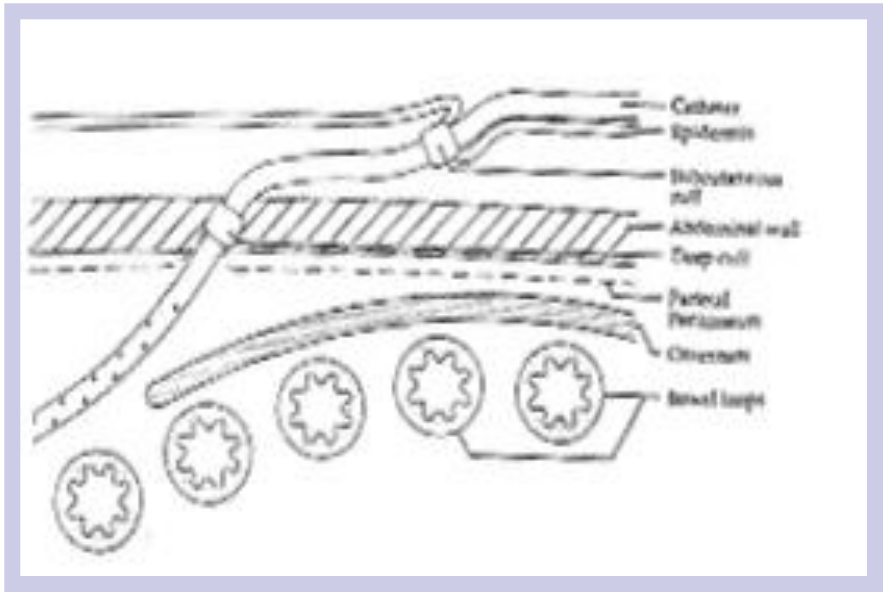
ikinci bir boşaltım organı

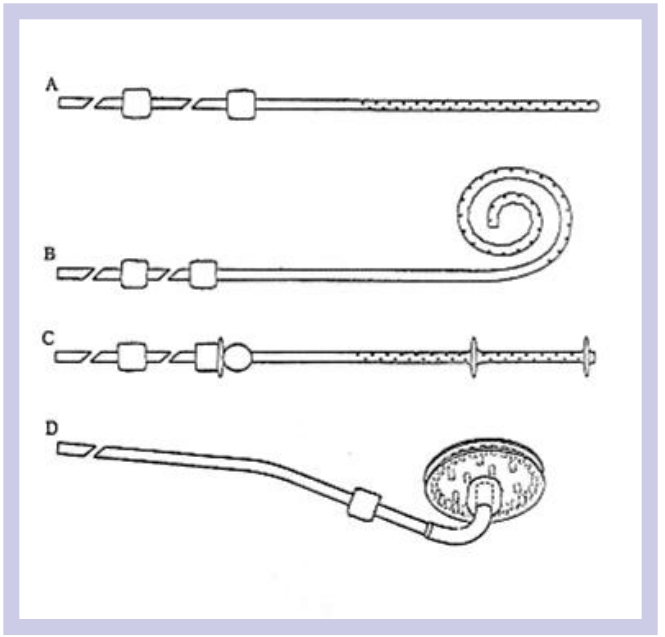
gibi çalışır!

İNSANDA?



Periton diyalizinde kullanılan kateterler:



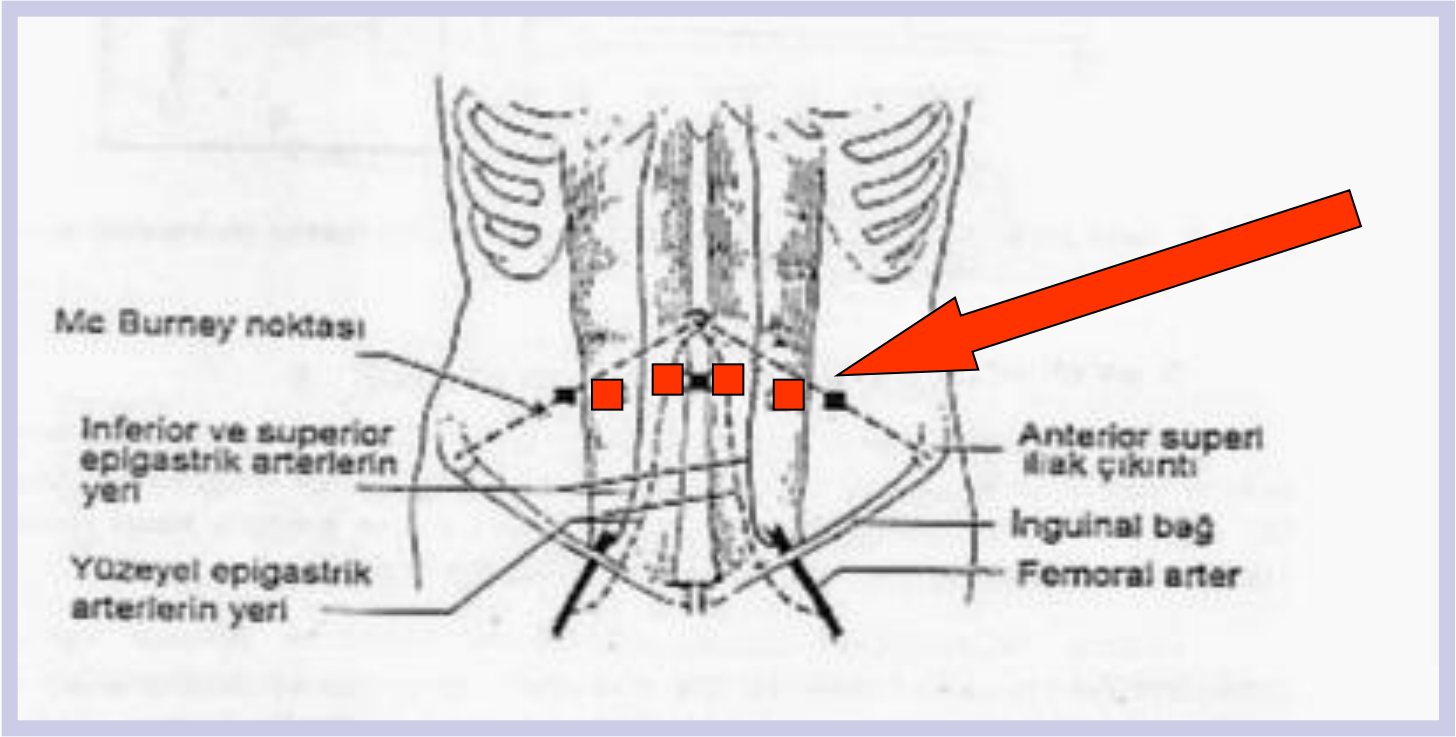


A-Tenckhoff kateteri

B-Kıvrık (coiled) Tenckhoff kateteri

C-Toronto-Western kateteri

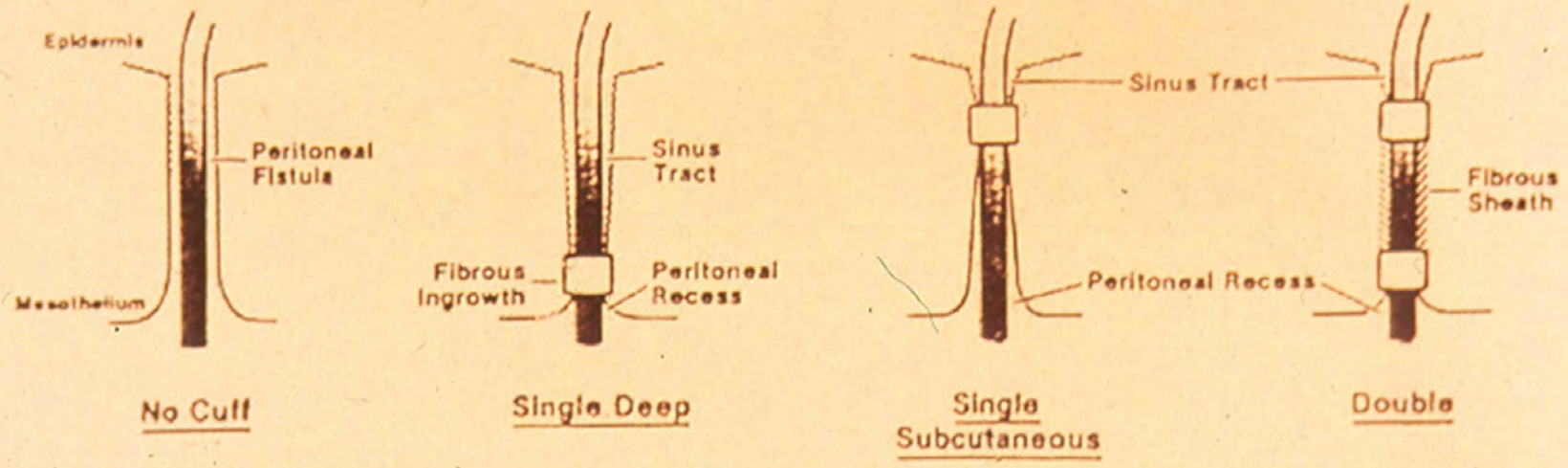
D-Life-disk-kateter

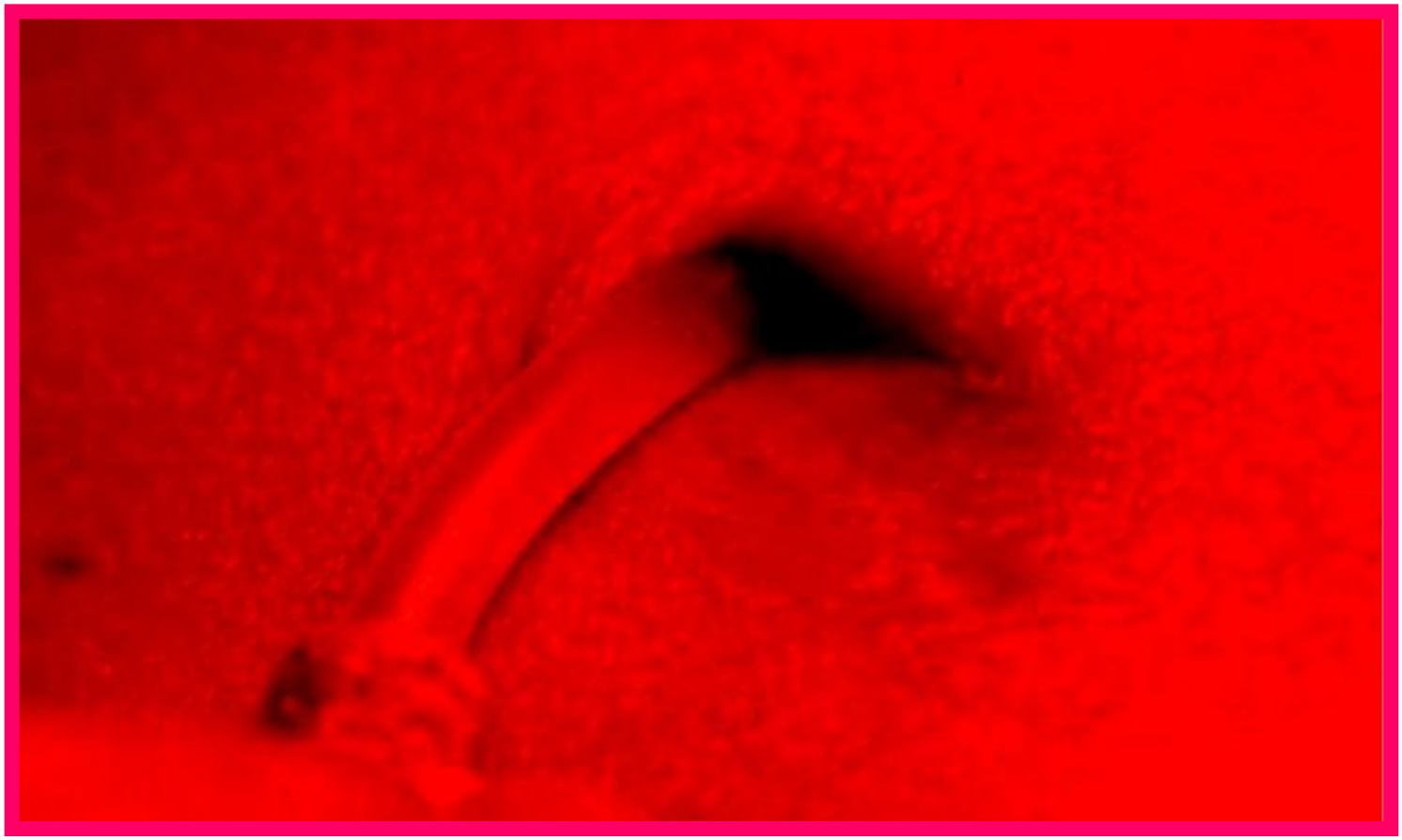


Kateter tercihan rectus abdominis içinden geçerek peritona ulaşır

Tenckhoff kateteri

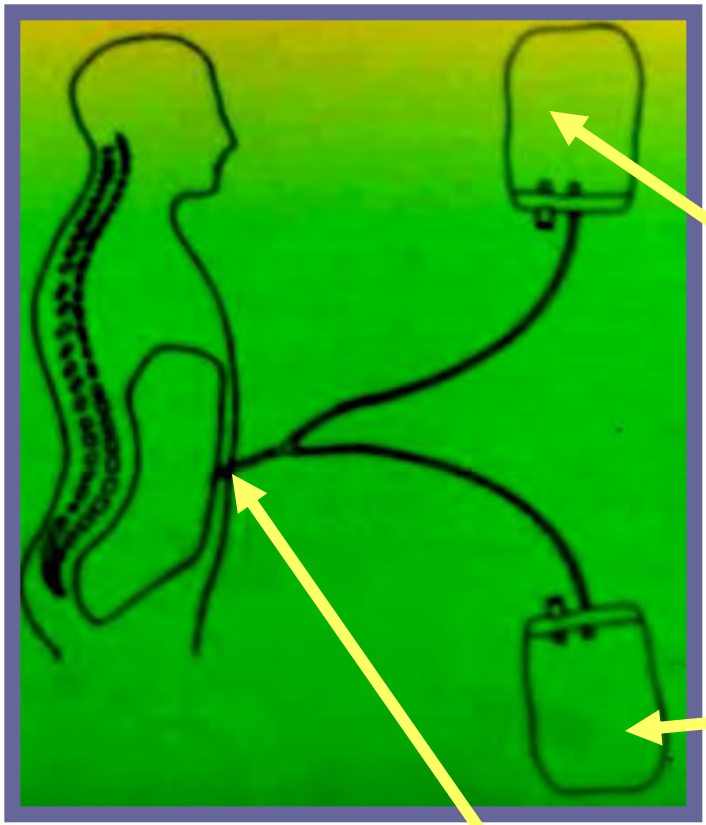
KATETER KEÇESİNİN KARIN DUVARINDAKİ YERİ





STANDARD PD SOLÜSYONUNUN BİLEŞİMİ

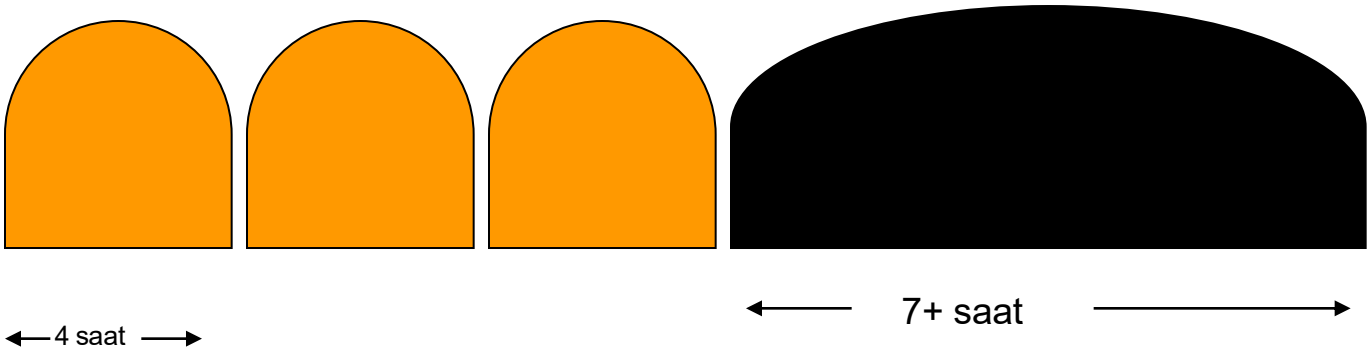
Sodyum	:132-134 mmol/L
Potasyum	:0-2 mmol/L
Kalsiyum	:1.75/1.25 mmol/L
Magnezyum	:0.25-0.75 mmol/L
Klorür	:95-107 mmol/L
Laktat	:35-40 mmol/L
Glukoz	:1.36-2.27-3.86 %
Ph	:5.2—5.5
Ozmolalite	:358-511 mOsm



Solüsyon torbaları

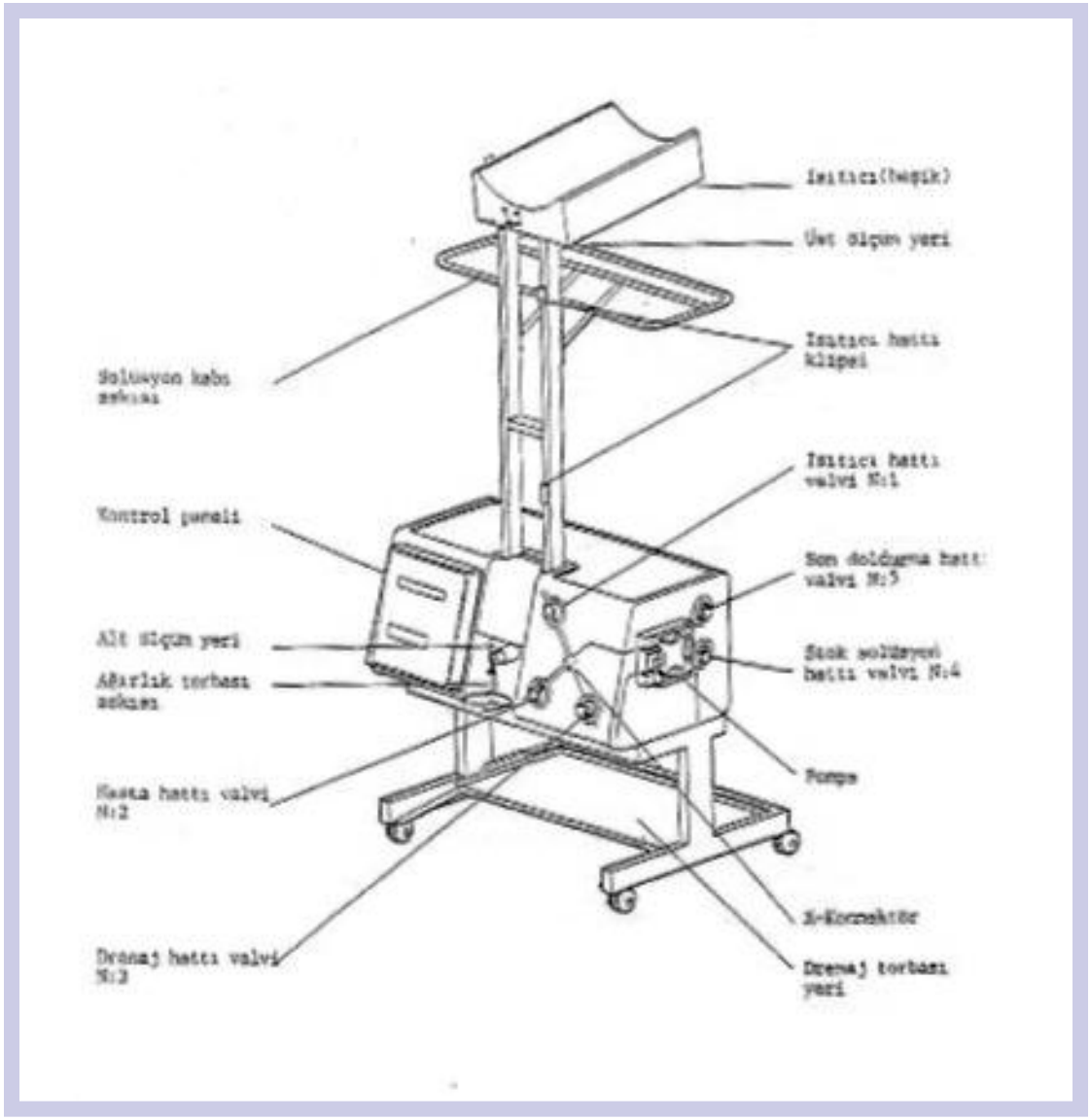
Kateter

Periton diyalizi türleri:



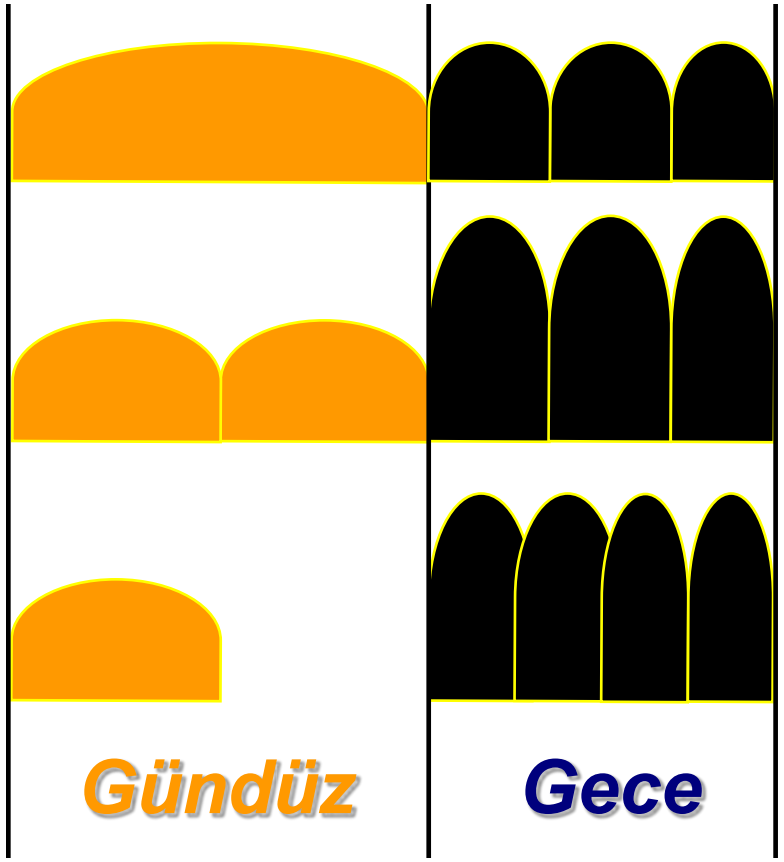
SÜREKLİ AYAKTAN PERİTON DİYALİZİ: SAPD

2-2.5 LX4



APD (ALETLİ PERİTON DİYALİZİ)

APD tiplerinden örnekler:



Standard CCPD*

Gece yüksek volüm ve gündüz iki değişimli CCPD

Gece yüksek volüm ve sıklıklı gündüz tek ve kısa değişimli CCPD

*CCPD: Continuous cyclic peritoneal dialysis

PERİTONEAL DİYALİZ SOLÜSYONLARINDA GLUKOZ

Ucuz, organizmaya yabancı olmayan

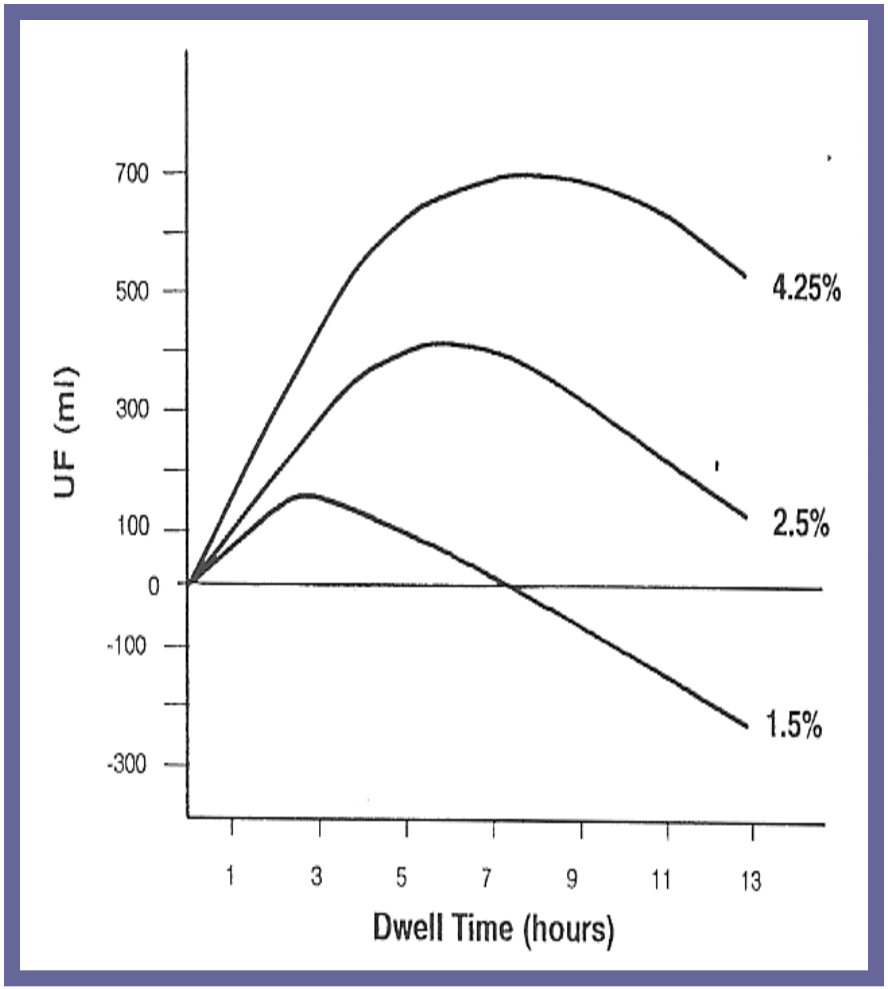
bir

ozmotik ajan.

1500-4500 mg/d'lik fizyolojik olmayan konsantrasyon

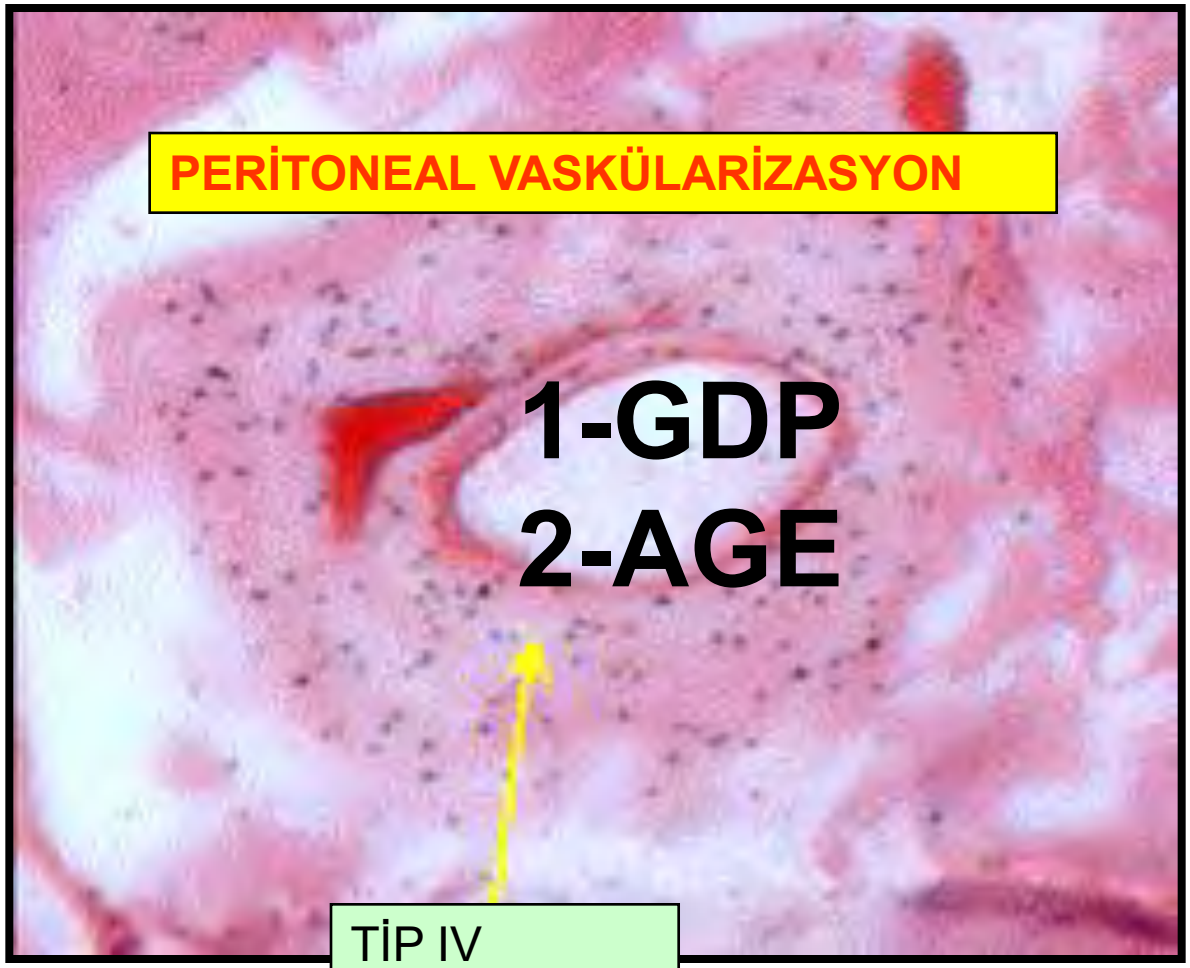
GLUKOZ VE ULTRAFİLTRASYON

Periton boşluğunda bekleme süresi içinde glukoz emilime uğradığından uzun bekleme sürelerinde ultrafiltrasyon kaybı ortaya çıkar.

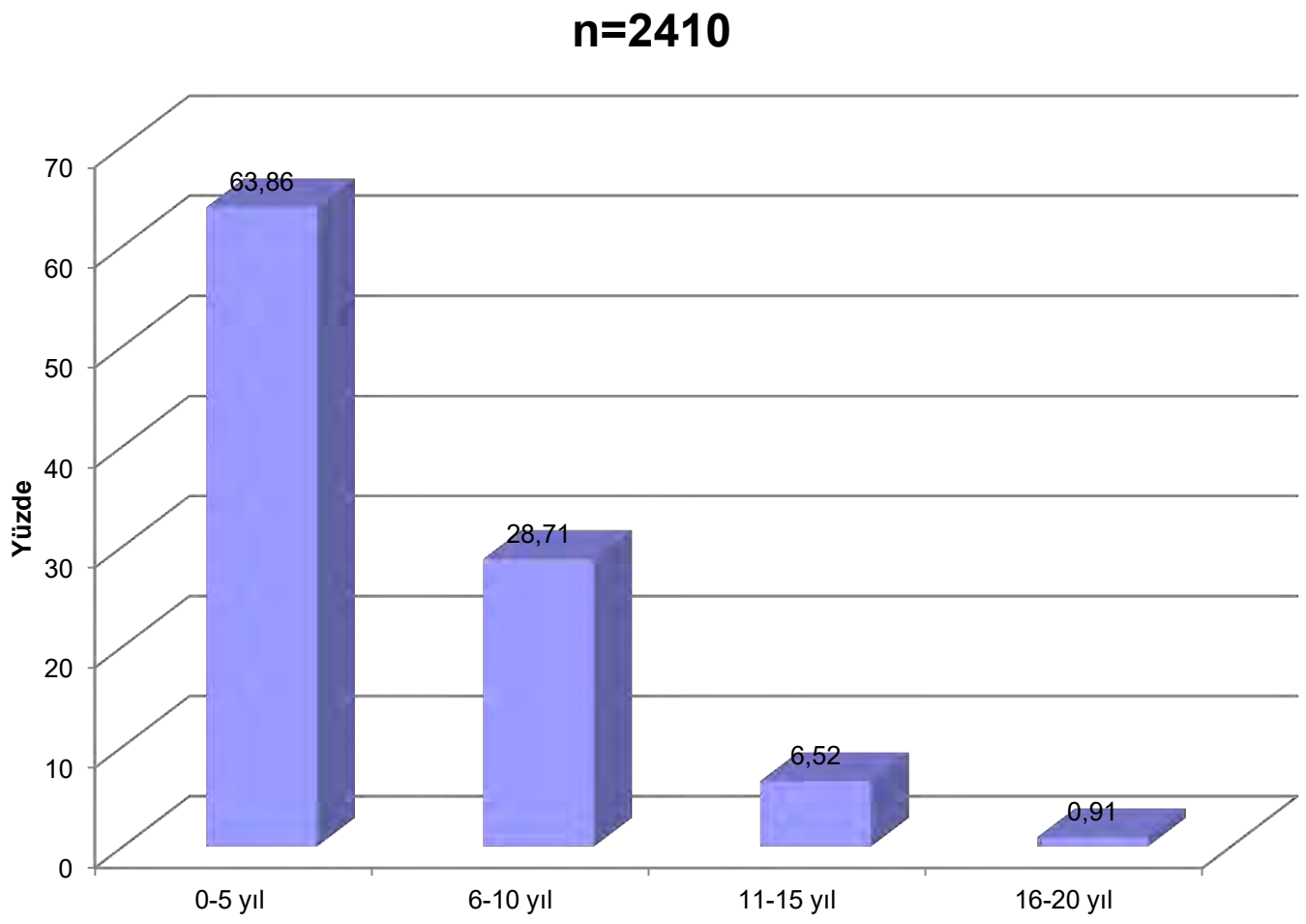


GLUKOZ DIŞI SOLÜSYONLAR

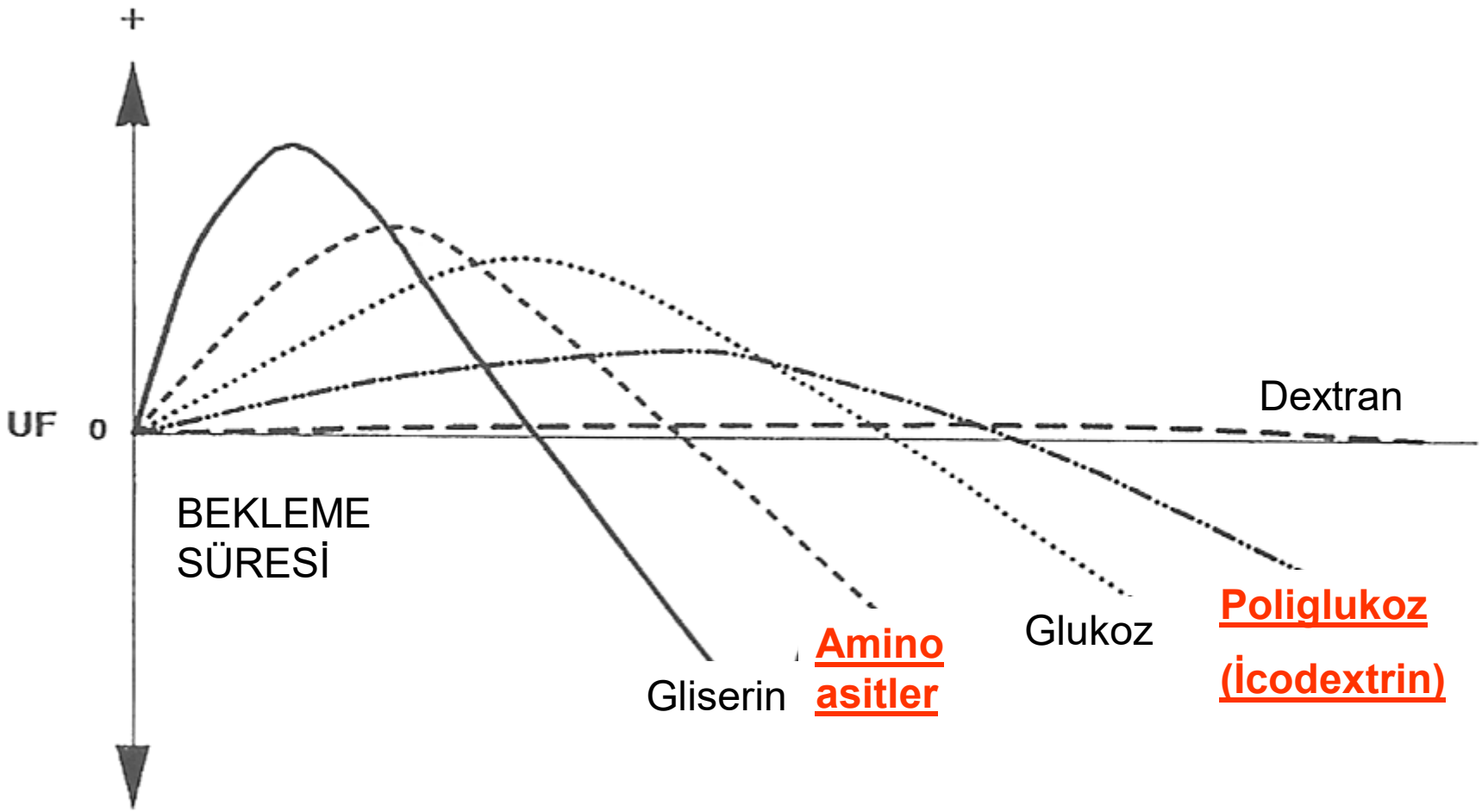
Glukoz uzun dönemde periton membranı için toksiktir!



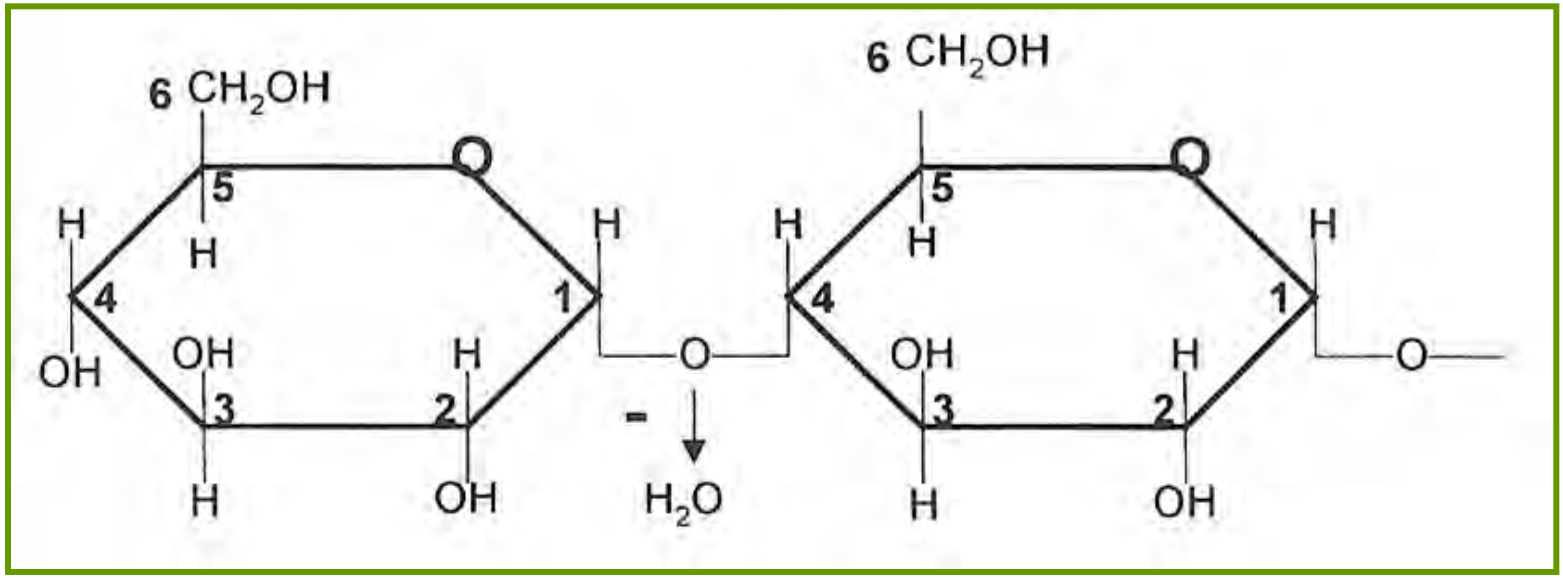
Periton Diyalizinde Diyaliz Süreleri (TND-2012)



Periton diyalizi pratiğine iki glukoz dışı ozmotik ajan girebilmiştir.



Poliglukoz (ICODEXTRIN)

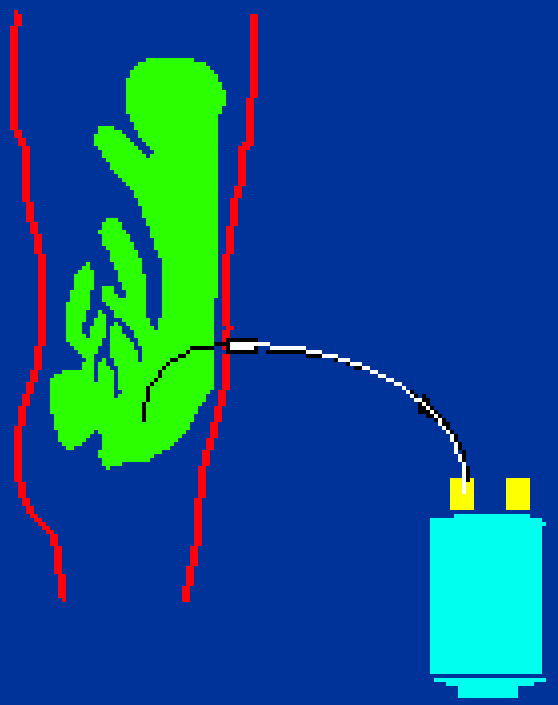


ICODEXTRIN *(Extraneal)*

- **Icodextrin kolloid ozmotik özellikleri olan bir maddedir.**
- **Nişastadan elde edilir.**
- **Glukoz moleküllerinin birbirine bağlanarak polimer oluşturması ile oluşur.**
- **Moleküler ağırlığı 13,000 ve 19,000 Dalton arası büyük ve daha küçük 5,000 ve 6,500 Dalton arası iki grup molekülün karışımından oluşur**
- **Bu moleküllerin bazıları maltoz gibi şekerlerdir.**

AMİNO ASİT SOLÜSYONLARI

PERİTON DİYALİZİNDE PROTEİN KAYBI

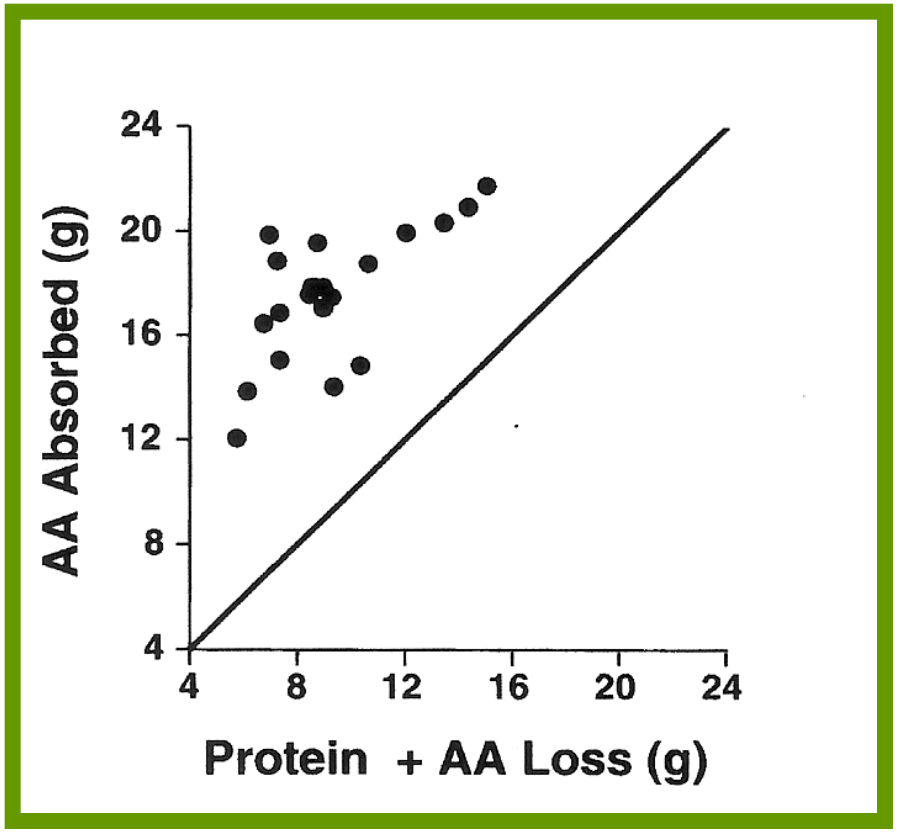


- ***Normal erişkinde protein ihtiyacı***

0.8g/kg

- ***PD Hastalarında durum:***
  - **3-4 g/gün amino asit kaybı**
  - **5-15 g protein kaybı**
  - **0.2g/kg toplam kayıp**
  - **Peritonit süresince kayıp çok daha fazla**
  - **Periton diyalizinde hastanın protein ihtiyacı daha fazladır:**

•1.2 -1.4 g/kg (yüksek biyolojik değerli)



%1.1 amino asit solüsyonunun

(Nutrineal)

günde bir kez 6 saatlik bir değişimde kullanımı diyalizatla tüm amino asit ve protein kayıplarından daha fazlasını hastaya kazandırmaktadır.

Jones MR, Gehr TW, Burkart JM, Hamburger RJ, Kraus AP, Piraino BM, Hagen T, Ogrinc FG, Wolfson M. *PDI 18, pp 210-216 1998*

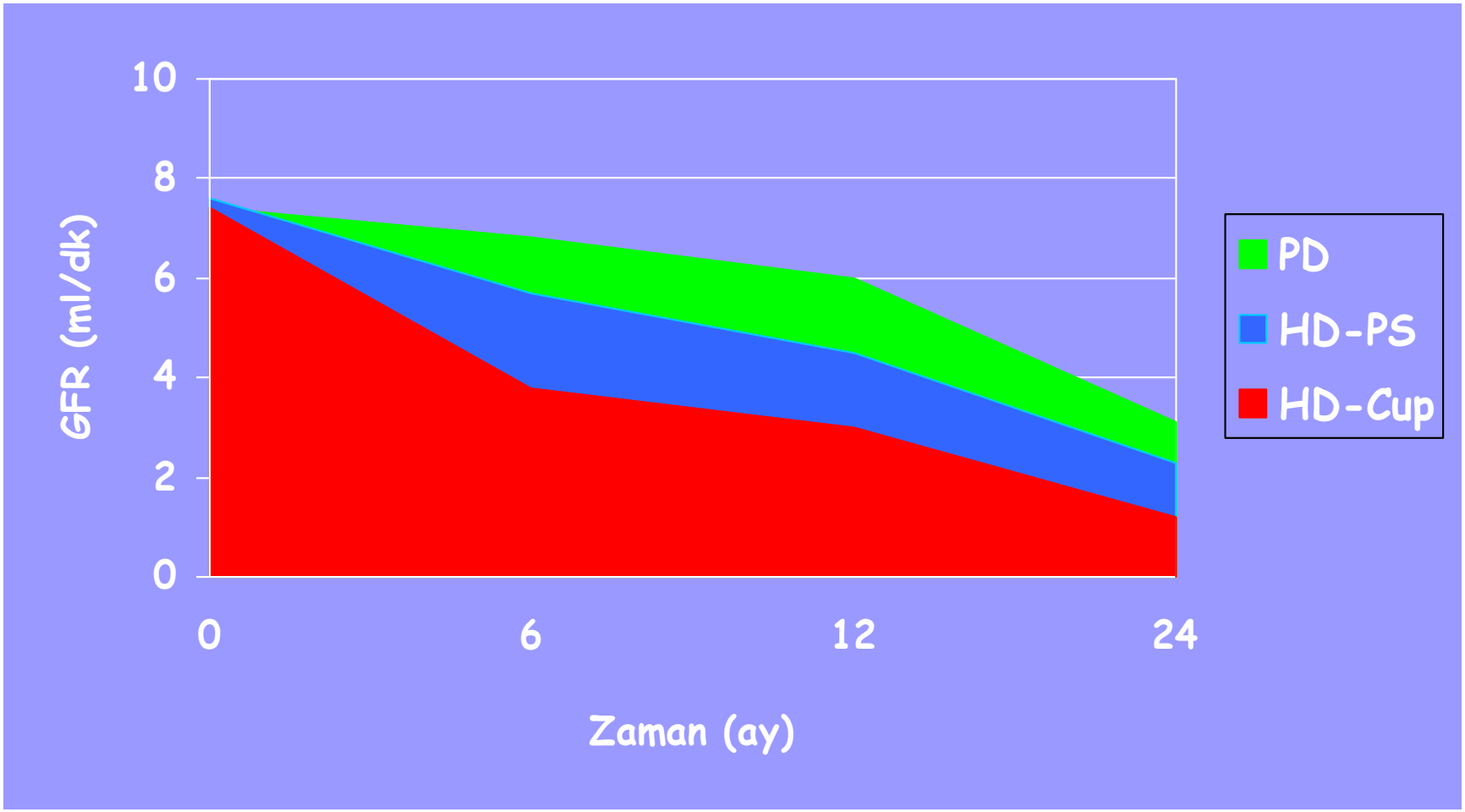
SAPD-AVANTAJ VE DEZAVANTAJLAR

AVANTAJLAR	DEZAVANTAJLAR
1. Hasta yaşam kalitesi (*Seyahat, evde tedavi*)	1.Peritonit
2. Daha liberal diyet ve sıvı alımı	2. Kateter sorunları
3. Daha iyi hipertansiyon kontrolü	3. Protein kayıpları
4. Daha iyi anemi kontrolü	4. Metabolik sendrom
5. Sabit kan kimyası	5. Uzun dönemde periton?
6. Çocuklar, yaşlılar,diyabetikler	
7. Daha ucuz	
8. Türkiye kaynaklı tek diyaliz metodu	

SAPD KONTRENDİKASYONLARI

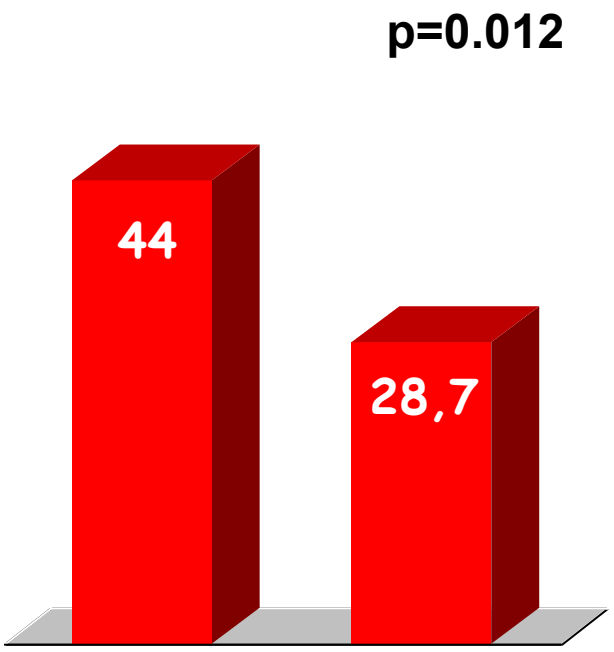
- Enflamatuar barsak hastalıkları.
- Abdominal abseler.
- Psikoz.
- Entellektüel yetersizlik.
- Çok sayıda geçirilmiş abdominal ameliyatlar

Diyaliz tipinin RRF üzerine etkisi



Rezidüel renal fonksiyonun hiperfosfatemiye etkisi

252 SAPD HASTASI

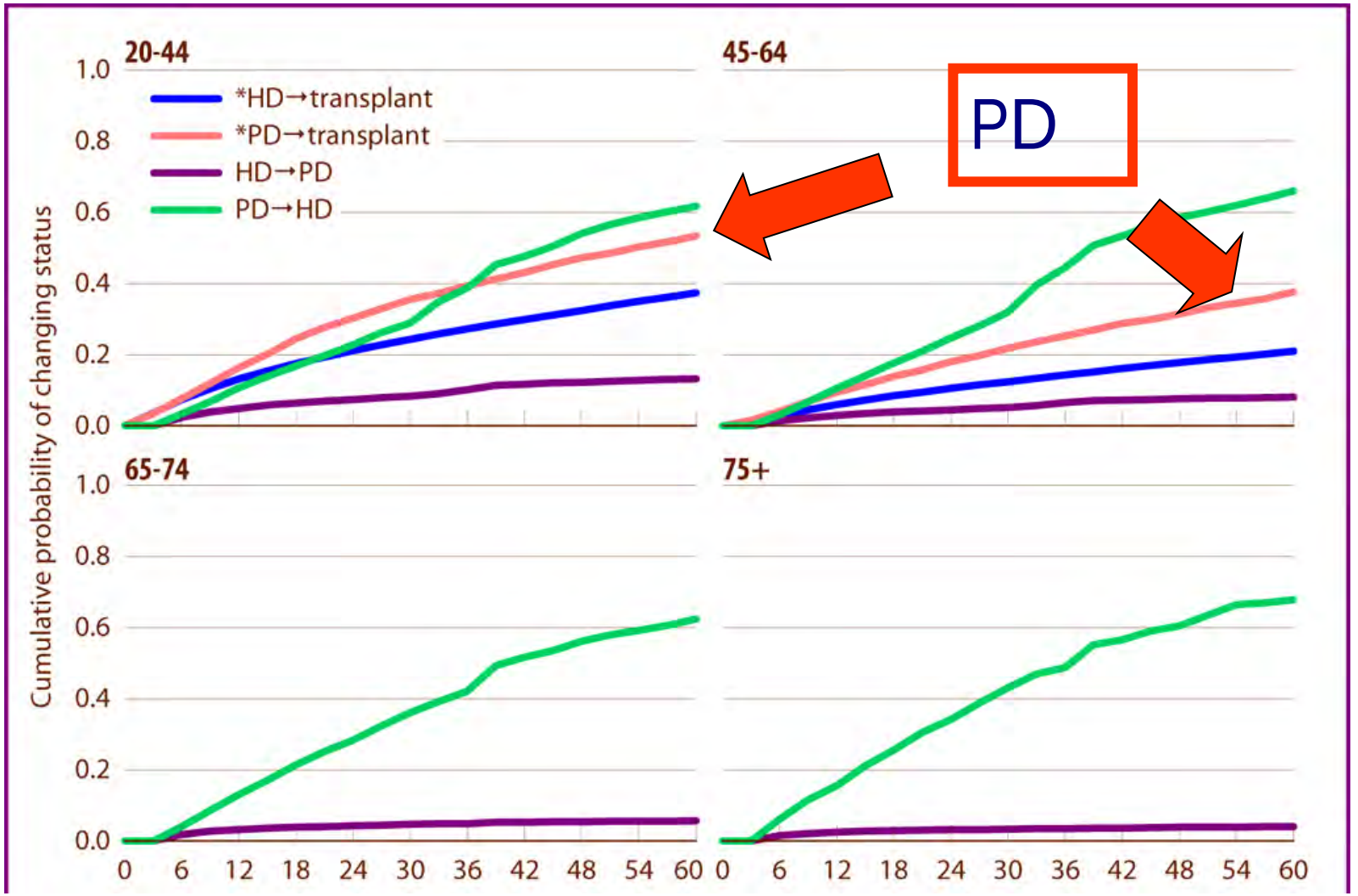


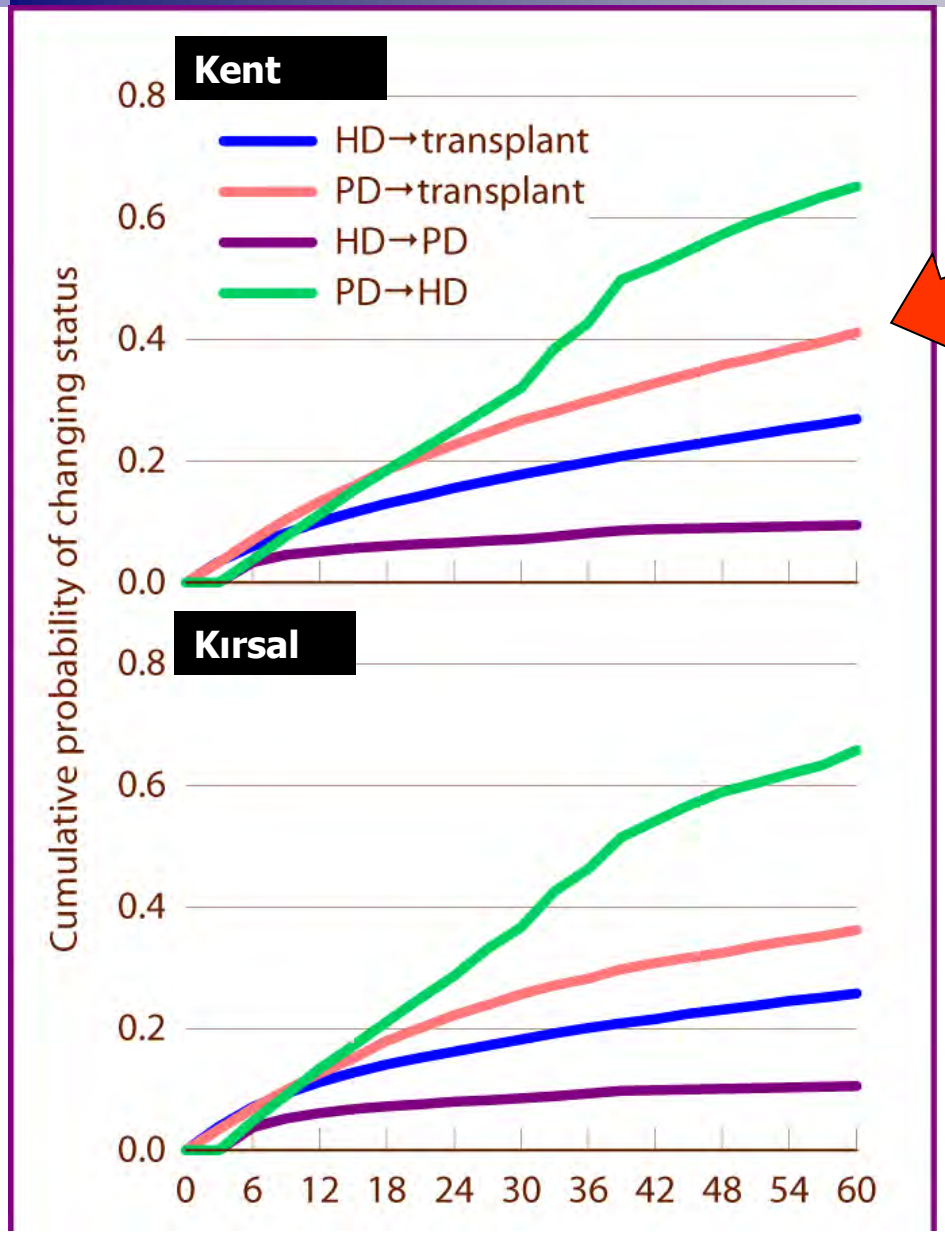
RRF'U OLAN HASTALARDA FOSFOR DÜZEYİNİN BELİRLEYİCİLERİ

	r	p
Erkek cins	-0.008	0.929
Yaş	-0.116	0.194
Vücut kitle indeksi	0.332	<0.001
Diyaliz süresi	-0.194	0.094
PTH	0.227	0.010
Serum albümin	0.085	0.344
nPNA	0.429	<0.001
Diyalitik Kt/V	-0.259	0.003
Rezidüel GFH	-0.392	<0.001

Wang AY, et al. Am J Kidney Dis 2004;43:712-20

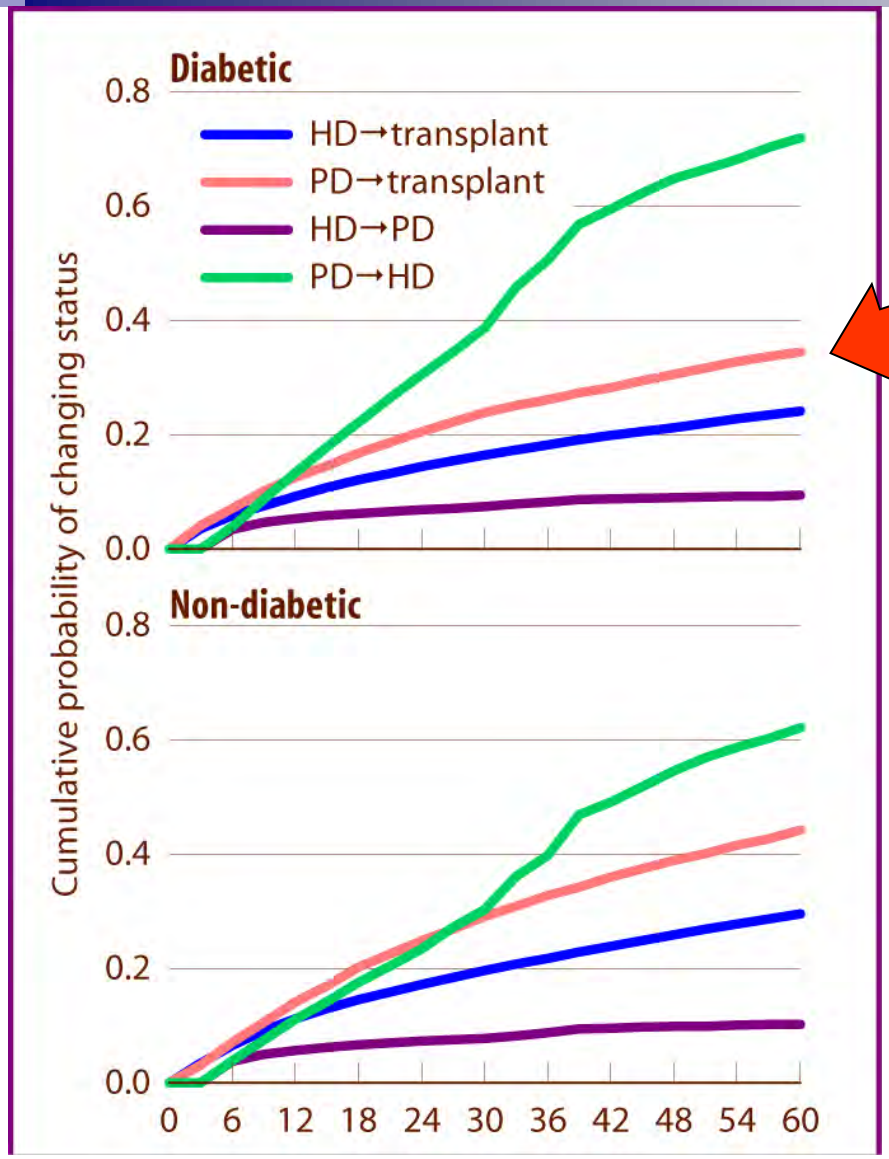
Diyaliz hastalarında yaşa göre transplantasyon alıcısı olma şansı
USRDS Verileri 2006





PD

USRDS VERİLERİ 2006 Yaşanan yere göre transplantasyon alıcısı olma beklentileri



PD

Diyabetik ve diyabetik olmayan hastalarda transplantasyon donörü olma beklentileri

USRDS 2006 Verileri

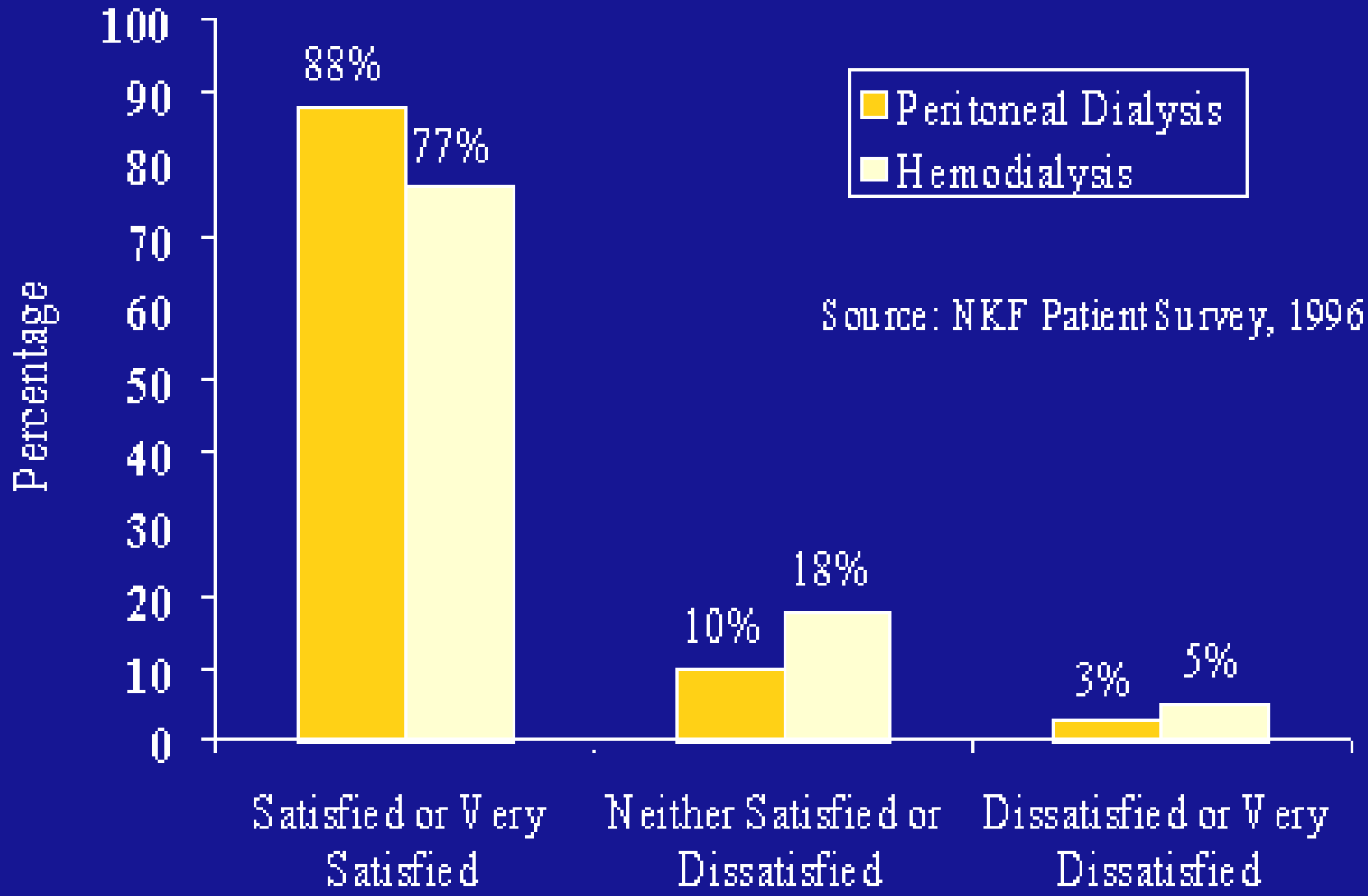
Diyaliz modalitelerinde rehabilitasyon

İNGİLİZ YAŞAM KALİTESİ ÇALIŞMASI

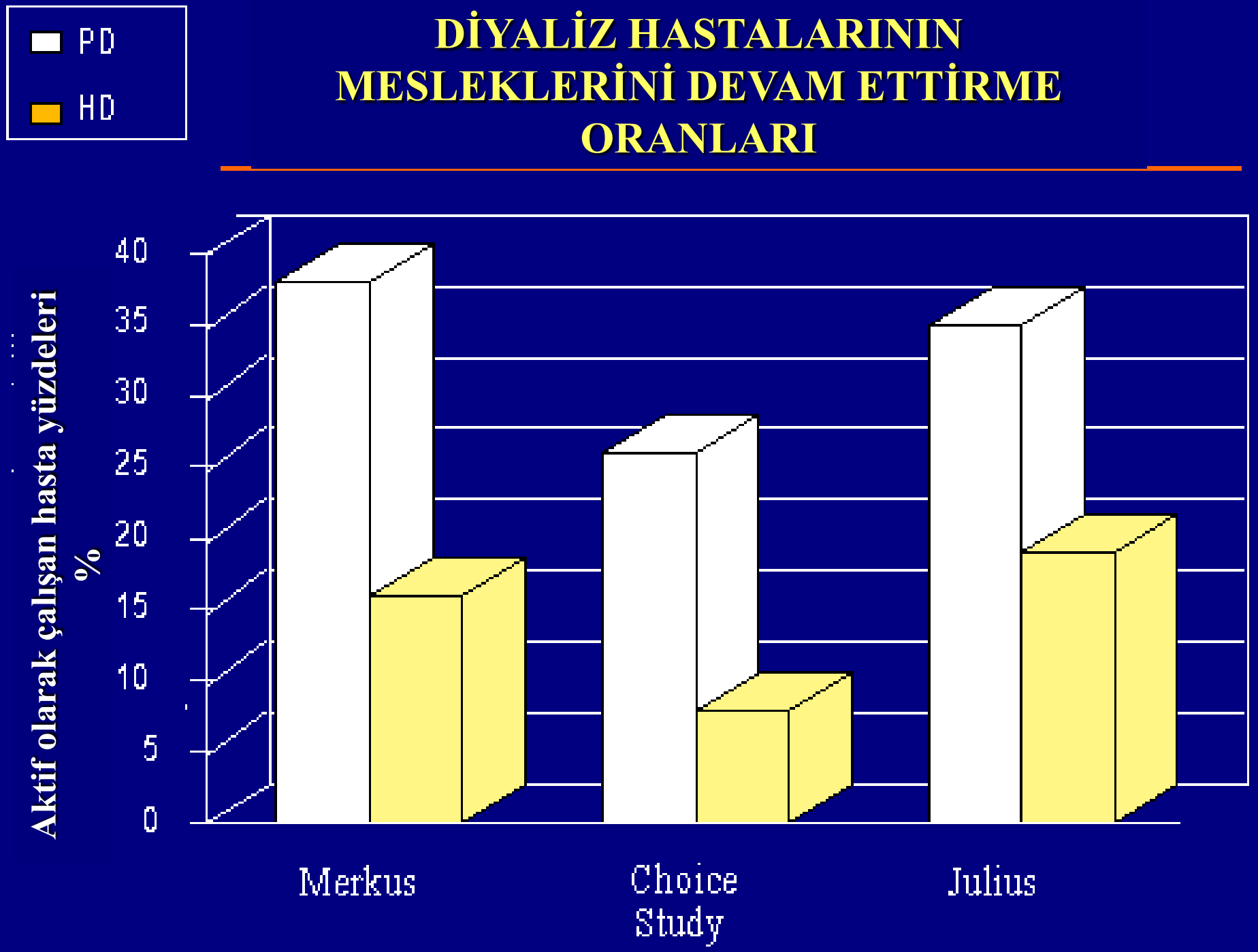
	MHD	EVHEMO	SAPD	TX	GEN POP
	%	%	%	%	%
Sosyal hayatta Ciddi bozulma	74.2	63.2	65.2	21.5	11.9
Günlük hayatta Ciddi bozulma	71.9	58.9	68.5	25.5	12.1
Cinsel hayatta ciddi bozulma	67.9	67.9	68.7	30.8	7.8

Gudex, Qual of Life Res 1995;4:359-65

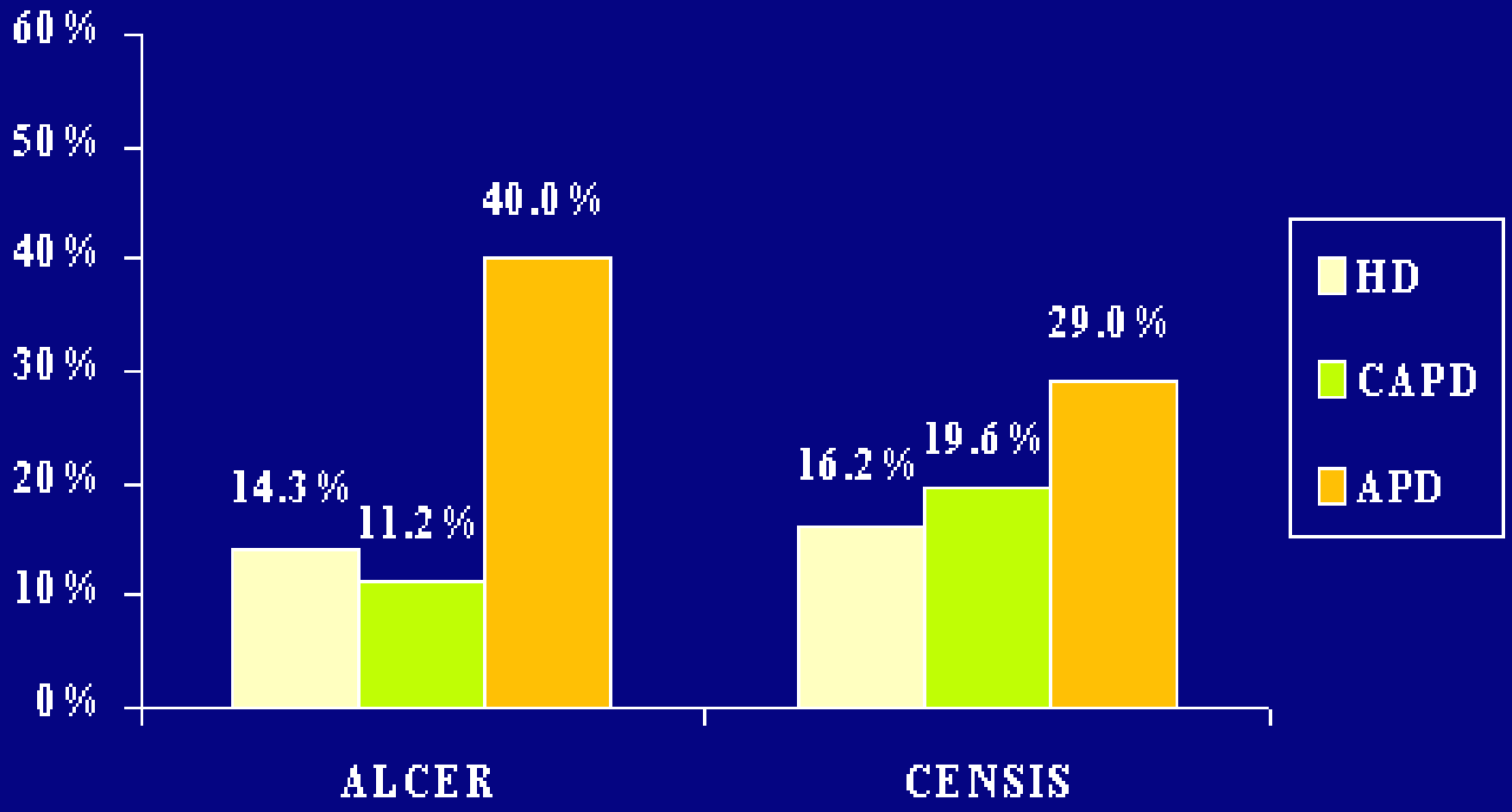
HALEN KULLANILAN DİYALİZ METODUNDAN MEMNUNİYET ORANI



DİYALİZ HASTALARININ MESLEKLERİNİ DEVAM ETTİRME ORANLARI

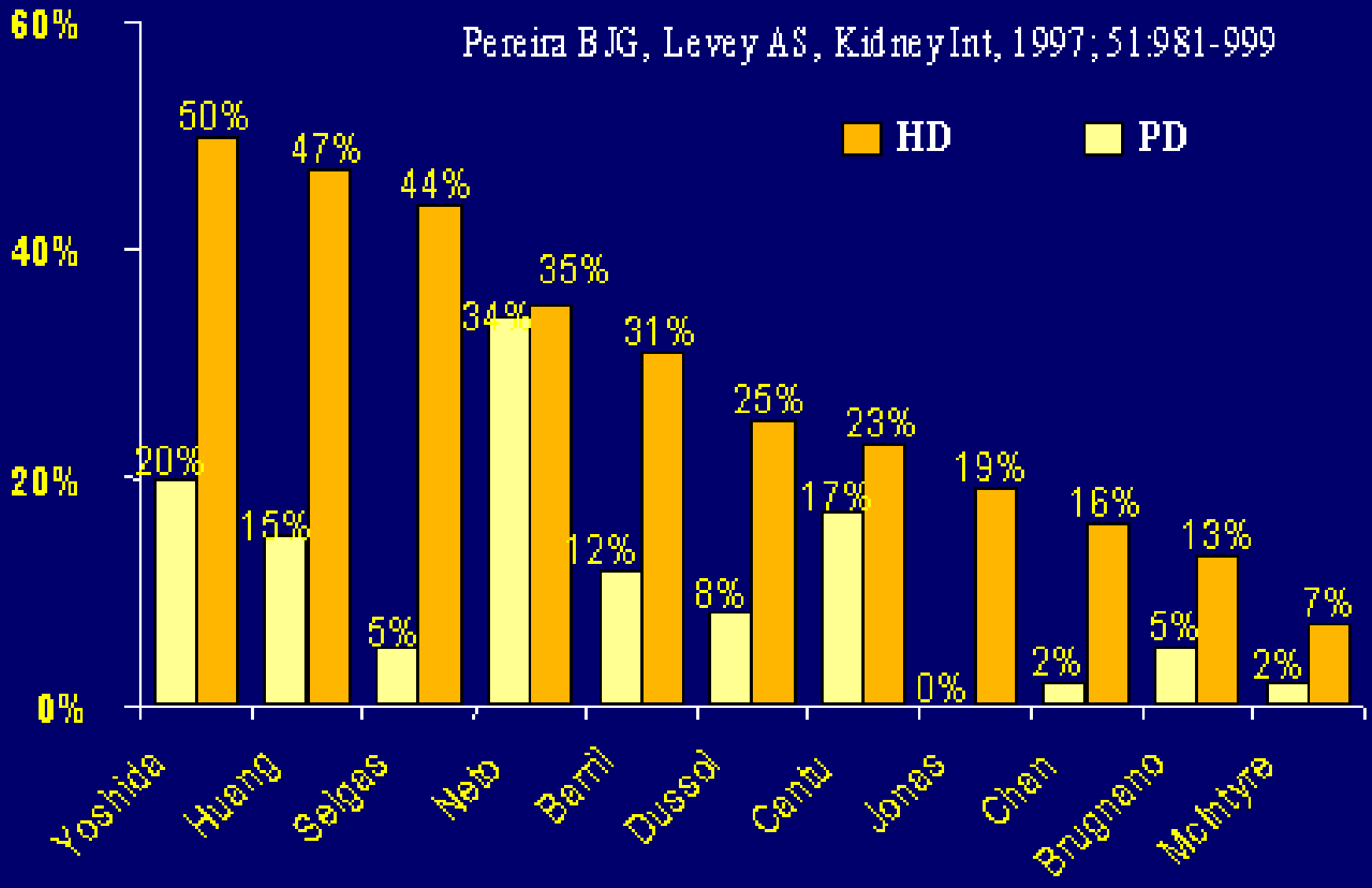


APD'DE DAHA DA FAZLA MESLEĞİNİ DEVAM ETTİRME OLANAĞI



ALCER, calidad de vida del paciente en diálisis, Spain, 1997
CENSIS, Verso l'Autosufficienza, Dialisi Peritoneale e Qualitá della Vita. Francoangeli Editore, Milano: 1997.

DİYALİZ MODALİTELERİNE GÖRE DİYALİZ HASTALARINDA HCV POZİTİFLİĞİ PREVALANSI



SDBY tedavi modalitelerinde maliyet

RENAL REPLASMAN TEDAVİLERİNİN MALİYET KARŞILAŞTIRILMASI (TÜRK NEFROLOJİ DERNEĞİ)

HD:

22 644 USD

PD:

22350 USD

TRANSPLANTASYON

23 393 (İlk yıl)

10 028 (Sonraki yıllar)

Sonuç?

- Son dönem böbrek hastalığında SAPD seçeneği bazı hasta grupları hariç daha uzun ve kaliteli yaşam beklentisi dahil avantajlar içermektedir.
- Mevcut kılavuzlar uygun her SDBY hastasının tedaviye PD ile başlamasını, daha sonra HD'e aktarılmasını önermektedir.
- Uygun hastada uygun renal replasman tedavisi seçimi için nefrolojik altyapının hastaya her üç tedavi seçeneğini (Tx-HD-PD) sunabilecek şekilde geliştirilmesi gerekmektedir.

TEŞEKKÜRLER