

Quality of Life after Renal Transplantation

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End stage renal disease invariably reduces the life span of patients. The treatment of choice for many patients is renal transplantation but this does not affect a cure. The aim of treatment is to improve renal function and thus to enhance the quality of life as much as possible. Surprisingly little research has been done concerning the quality of life after renal transplantation.¹ In this study involving five patients with ESRD awaiting renal transplantation and five patients who had received a graft within the last six months, the method of exploratory study with qualitative design was used. All patients received abundant technical information about renal transplantation and preoperative preparation but detailed information regarding the negative effects of transplantation including the side effects of immunosuppressive medication appeared lacking. The main source of stress preoperatively was the need to undergo dialysis, awaiting the summons to the hospital and the social isolation imposed by the chronic ailment, frequent hospital visits and resultant fatigue. Post-transplantation patients were remarkably free of anxiety regarding having to attend hospital frequently for follow-up tests. Quality of life improved after transplantation despite the persistence of renal symptoms and patients felt privileged to have been offered the option of transplantation

For decades, success in renal transplantation has been measured in terms of numbers like 1 year and 5 year patient survival, 1 and 5 year graft survival, blood pressure and renal function tests. But the real question is how the patients are faring in their quality of life as measured in a variety of parameters including life satisfaction, well being and psychological affect.² With the improvement in short term and long term graft and patient survival after renal transplantation over the last few decades, Health-Related Quality of Life (HRQL) is becoming an important additional outcome parameter.³ Global and disease specific instruments are available to evaluate objective and subjective QOL. SF36 is the most popular global tool for evaluation

of QOL. The disease specific tools used are Kidney Transplant Questionnaire (KTQ),⁴ the Kidney Disease Questionnaire (KDQ)⁴ and the Kidney Disease-Quality of Life (KDQOL).⁵ These tools are sensitive enough to determine the longitudinal changes of a disease but they are not appropriate to compare different diseases.

The KTQ cited contains 26 questions in five domains (physical symptoms, depression, fatigue, relationship with others, frustration) each of which can be scored on a scale from 1 to 7, where the lowest score represents the lowest QOL; these questionnaires are ideally done in the native language.

The KDQOL is used to evaluate chronic renal disease and dialysis patients, later used to evaluate transplant patients and to compare them to patients on haemo and peritoneal dialysis. The original KDQOL covers eleven dimensions with a different number of items. Symptoms constitute 34 items, effects of kidney disease 20 items, burden of kidney disease 4 items, cognitive function 6 items, work status 4 items, sexual functions 4 items, quality of social interactions 4 items, sleep 9 items, social support 4 items and patient satisfaction 2 items. For dialysis patients dialysis staff encouragement has 6 items to complete the list. Higher scores denote better QOL.

No single method is ideal for measuring HRQL in all circumstances.

Objective measures of life quality have become an adjuvant tool in the analysis of therapeutic interventions and individuals' level of satisfaction with their health and treatment. Quality of life can be assessed using both general and specific instruments. The measure of quality of life in chronic degenerative disease patients has been investigated in recent years by several investigators all aimed at identifying the changes needed for improving these patients' well-being and adequacy of their rehabilitation.^{6,7}

Renal failure is a slow progressive disease with varying

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rates of progression with resultant slow loss of quality of life. As renal failure advances, patients start to have more symptoms that interfere with their daily activities. More advanced stages of renal disease could directly impact in the individual's perception of their quality of life.⁸ When dialysis is initiated in the treatment schedule whether it is hemodialysis, peritoneal dialysis or CAPD, it has also a definite impact on the assessment of patient's quality of life, since not all symptoms are eliminated with treatment. Renal transplant is advocated as a mode of treatment that would assure the individual back to their daily activities. But in reality not all renal transplants result in satisfactory outcomes. Many patients develop vascular problems, rejection episodes, bacterial or viral infections, obstructive hydronephrosis or lymphatic problems.⁹ This is reflected in the not so satisfactory scores of quality of life especially in the individuals experiencing acute graft rejection or adverse events resulting from immunosuppressive therapy.¹⁰

The development of new more powerful immunosuppressive drugs has resulted in better patient and graft survival creating a larger set of chronic rejection patients who need to restart dialysis for survival. For these patients restarting dialysis will have a negative impact on the assessment of quality of life especially the active transplant patients. On the other hand the subset of patients who had frequent complications after their transplant may see restarting dialysis as a way to improve their quality of life.¹¹

In a major study the quality of life of 859 patients undergoing dialysis or transplantation was assessed with the goal of ascertaining objectively and subjectively the quality of life. The study revealed that 79% transplant recipients were able to function at near normal levels, while 47 and 59% patients on dialysis did well depending of the mode of dialysis. Nearly 75% of transplant recipients were able to work as compared to 24 and 59% in the other groups. On the three subjective measures - life satisfaction, well being and psychological affect transplant patients had a higher quality of life than patients on dialysis. Among patients treated with dialysis, those on home dialysis had the best quality of life. The quality of life of transplant recipients compared well with that of the general population while patients undergoing dialysis did not work or function at the same level as people in the general population.⁸

In general HRQL improved after successful renal

transplantation compared to dialysis, this effect was more pronounced in male patients than in female patients. These studies also document for the first time that renal transplantation is cheaper in the long term, associated with less mortality but also provides better quality of life to patients. These trials also show that physical activity, energy and appearance are important domains influenced by the mandatory immunosuppressive regimens.³

END NOTE

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