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

The Patient-Clinician Connection in Managing CKD-aP

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Dr. Manenti:
This is CME on ReachMD, and I'm Dr. Lucio Manenti. Here with me today is Dr. James Burton.

So what are the best practices that clinicians may implement with their patients when talking about symptoms, treatment, expectations, and implementation?

Dr. Burton:
We know from DOPPS data that about a quarter, 25% of people on dialysis who have any degree of pruritus do not actually mention it at all to a member of their healthcare team. And even if patients have got moderate to severe pruritus, over 15%, somewhere around 17% to 18% of those individuals don't report that symptom either.

And the reasons behind that are complicated, and I think we have to acknowledge our place as healthcare professionals in that conundrum. I guess a lack of knowledge of new treatments is part of that. We might be reluctant to talk to patients or ask them if we're unaware of treatment pathways, that feeling of learned helplessness that we don't want to ask things if we can't do anything about it.

But actually, an Italian study of nearly 2,000 patients in more than 150 dialysis centers showed us that just having those conversations meant that there was a more positive outcome for patients. That increase in communication is really important and improves that perception. Although less than 20% of people in that study with severe itch felt they were satisfied with the responses that came from their clinical team, and 40% of people believed that, actually, that there was nothing that could be done to alleviate their symptoms.

And more data from the CENSUS-EU study, which we talked about in some of the other episodes, 90 dialysis centers across Europe showed a similar picture around the prevalence, but also showed that although 50% of people experience itch to some degree, almost half of that number, around 48% of people who've ever reported moderate to severe itch, only about 48% of those were actually on a treatment that would be considered a treatment for pruritus.

So when we're talking about the best practice that we might use, talking about symptoms and expectations and implementation, I guess the key from that is to ask. The first thing to do is to ask—use one of those validated tools to ask people, do they itch? Listen. Listen and keep the conversation going. That, we know, improves the experience for people. And then take that information, record it, write it down, and create a management plan.

We need to educate ourselves that actually there is a management plan, and we've talked about DFK, one of the agents that's now licensed for the treatment of CKD-associated pruritus. So educate ourselves and then implement that, involving the patient so that they know the time scale and the effect that they would expect from that.

Dr. Manenti:
Yes, I fully agree with you, Jim. I, like in the past, the nephrologist but also the dialysis nurse must address the diagnosis of CKD-aP actively by offering the patient the itch scale at least I think—I think you agree with me—almost 2 or 3 times a year. It is unbelievable that this important symptom in the past has been treated as a Cinderella of nephrology for so many years; yet it is a disorder that we know increases patient discomfort, depression, cardiovascular morbidity and mortality. Even the patient itself, as you said, does not report the symptom, by not linking it to this status as a patient on dialysis.

What do you think about the approach of scheduled controls about itch in pre-fixed times?

Dr. Burton:
I think you are absolutely right. The one thing that is completely predictable about CKD-associated pruritus is that it's totally unpredictable. It can affect anywhere and come on at any time with different intensities.

But it's one of those things. It's not like fatigue, where actually the treatment of that is incredibly complex. The treatment of itch now, we have a fairly straightforward algorithm that we could use.

So I totally agree—every single time I have a clinical interaction with my patients in clinic, every 3 months or so, I'm asking them about itch because we know it's unpredictable. It can come and go. But I think absolutely, what you've said, make it part of our routine assessment and listen to patients and make them feel we can do something about it.

What about people who mention their symptom of itch, their pruritus, and yet there's a delay to diagnosis or a misdiagnosis that causes a delay to treatment?

Dr. Manenti:
Yes, I think that the nephrologist must be aware that if dialysis patients talk about pruritus, the more relevant the diagnosis is. If it is a chronic pruritus, it is certainly a uremic pruritus. Then we have to make some exams, first of all to see the derma. If we have a derma without lesions or only scratching lesions, this, I think, it is not necessary to involve dermatologists because we have the symptoms that is prevalent and relevant in dialysis patients.

Dr. Burton:
I think that's exactly right. I think it should be the first thing that comes to mind. It's important to exclude those other diagnoses, but of course we know even from that study that worst itch severity is still associated really closely with things like poor quality of life, problems with sleep, day-to-day activities, and mood. So it's really important to get that diagnosis, to exclude others, but to think of CKD-associated pruritus nice and early.

Dr. Manenti:
Well, this has been a good discussion, but our time is up, unfortunately. Thanks for listening.

Announcer:
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