Palliative Nephrology: Conservative Management and End-of-Life Care in CKD

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Learning Objectives

By the end of this session, students will be able to: - Define conservative (non-dialysis) kidney management and identify appropriate candidates - Facilitate goals-of-care conversations with CKD G5 patients and families - Manage dialysis withdrawal with compassionate, safe protocols - Understand advance directives and shared decision-making in ESKD - Recognize and manage common palliative symptoms in uremia (pruritus, pain, nausea, restless legs) - Apply validated tools (IPOS-Renal, ESAS-Renal, Surprise Question) for prognostication - Estimate survival without dialysis and discuss realistic expectations

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I. Conservative (Non-Dialysis) Kidney Management

Definition and Eligibility

Conservative Kidney Management (CKM) is a holistic, individualized approach to CKD progression without initiating renal replacement therapy (RRT). It focuses on: - Symptom management - Slowing GFR decline through renoprotective therapy - Advance care planning - Psychosocial support - Quality of life optimization - Palliative care when appropriate

Who Is a Candidate for CKM?

Primary Indications: 1. **Patient preference:** Patient explicitly chooses not to pursue dialysis 2. **Poor prognosis without dialysis:** Estimated life expectancy <1–2 years even on dialysis 3. **Significant comorbidity:** Multiple organ failure, advanced cancer, severe frailty 4. **Late referral (eGFR <10 at diagnosis):** Insufficient time for fistula/PD catheter planning 5. **High surgical risk:** Extensive cardiac disease, recent MI, severe lung disease 6. **Severe functional impairment:** Inability to tolerate dialysis logistics and side effects 7. **Advanced dementia or severe cognitive decline** without advance directive favoring dialysis

Relative Contraindications to CKM:

- Young, robust patient with no major comorbidities (should typically pursue dialysis)
- Acute reversible process (post-obstruction AKI, sepsis-related AKI recoverable to non-ESKD)
- Potential renal transplant candidate with good life expectancy

Age-Based Data on CKM Outcomes

Age Group	% Choosing CKM	Median Survival (CKM)	Median Survival (Dialysis)	Notes
65–74	15–20%	11–14 months	36–48 months	Depends on comorbidities
75–84	25–35%	8–12 months	24–36 months	Frailty affects both groups
≥85	40–50%	6–9 months	12–20 months	Very high mortality on dialysis
High comorbidity (any age)	30–50%	4–8 months	8–16 months	Cancer, advanced CHF worsen prognosis

Key Point: Survival outcomes on dialysis in elderly or frail populations are often poor. CKM with good symptom management frequently offers better quality of life in final months.

II. Goals-of-Care Conversations and Shared Decision-Making

Framework for Difficult Conversations

Palliative nephrologists use the **REMAP model**:

R – Reframe the situation

- Shift from "We're giving up" to "We're choosing comfort and quality"
- Acknowledge kidney disease is advancing

- Explain realistic options without minimizing either path

Example: "Your kidneys are getting weaker, and we need to talk about your priorities. Some patients choose dialysis because they want to extend time with family. Others focus on staying comfortable at home. Both are okay—let's talk about what matters most to you."

E – Elicit understanding and values

- Ask open-ended questions:
  - "What do you already know about your kidney disease?"
  - "What worries you most about the future?"
  - "What gives your life meaning right now?"
  - "If your health were to decline, what would you want us to focus on?"
- Listen without correcting; understand their perspective
- Explore past experiences (family members on dialysis, hospice, etc.)

M – Make recommendations

- Provide medically honest advice based on clinical judgment
- Acknowledge uncertainty ("We think dialysis might help, but we can't know for sure")
- Tailor recommendation to their values
- Recommend one path without abandoning the other

Example: "Based on your values around staying home and spending time with family, I'd recommend we focus on keeping you comfortable without dialysis. We can manage your symptoms well at home or with home palliative care."

A – Affirm choice and agreement

- Document patient's stated goals
- Align clinical team around the decision
- Schedule follow-up to revisit if patient's mind changes
- Provide written advance directives reflecting the decision

P – Plan ongoing care

- Regular check-ins (monthly or more frequent as eGFR declines)
- Introduce palliative care team early
- Arrange home health, hospice, chaplaincy as needed
- Manage symptoms proactively

The Surprise Question: Assessing Prognosis

Ask patient or surrogate: **"Would I be surprised if this patient died within 12 months?"**

- **"No, I would not be surprised"** ☐ High mortality risk; discuss palliative approach
- **"Yes, I would be surprised"** ☐ Expected survival >1 year; continue curative/dialysis planning

This simple question predicts mortality better than many objective measures and guides care intensity.

Barriers to Goals-of-Care Discussions

Barrier	Strategy
Physician discomfort with mortality	Train in palliative communication; practice with simulations
Patient/family denial	Validate emotions; frame discussion as "being prepared," not giving up
Language or cultural barriers	Use professional interpreters; involve cultural liaisons; allow more time
Patient indecision	Frame as "trial period": start conservative, switch to dialysis if struggling
Family disagreement	Include key family members; clarify patient's own wishes; involve ethics
Time pressure	Schedule dedicated appointment; avoid rushing; allow follow-up

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III. Dialysis Withdrawal Decision-Making

When Dialysis Withdrawal Becomes Appropriate

Dialysis withdrawal is one of the **most common** causes of death in ESKD patients. Indications include:

1. **Patient-initiated:** Patient explicitly requests to stop
2. **Declining quality of life:** Patient reports dialysis burden outweighs benefit
3. **Worsening prognosis:** New terminal diagnosis (advanced cancer, advanced dementia, heart failure with EF <20%)
4. **Intractable symptoms:** Pain, nausea, or bleeding refractory to management
5. **Medical inability:** Vascular access failure, recurrent sepsis, hemodynamic instability
6. **Cognitive decline:** Patient loses decision-making capacity; advance directive favors withdrawal

Prevalence and Timing of Withdrawal

- **10–20% of dialysis deaths** are due to treatment withdrawal
- **Median survival after withdrawal:** 8–14 days (range: 1–365 days)
- **Most die within 2 weeks**, but some survive months if small, stable patients or have residual renal function
- **Survival longer in:** Peritoneal dialysis patients (slower fluid accumulation), younger patients, those with residual urine output

Ethical and Legal Framework

Withdrawal is morally and legally equivalent to: Not starting dialysis in the first place

Key principles: - **Autonomy:** Patient's informed choice takes precedence over clinician judgment - **Beneficence:** Withdrawing dialysis causing distressing death is not beneficial - **Palliative fo-**

cus: Transition to comfort-focused care immediately - **Surrogate decision-making:** If incapacitated, surrogate applies patient's known wishes or best interest standard

Communication Before Withdrawal

Key Conversation Points:

1. **Acknowledge the decision:** "I hear you want to stop dialysis. That's your right, and I respect it."
2. **Clarify reasoning:** Understand their motivation (burden, symptoms, prognosis, values)
3. **Discuss what to expect:**
   - Timeline: "People typically live 1–3 weeks after stopping dialysis"
   - Symptoms: Fatigue, shortness of breath, confusion, restlessness possible
   - Goals: "Our focus is now on your comfort and peace"
4. **Pain and symptom management:** "We'll use medications to keep you comfortable"
5. **Family presence:** Encourage loved ones to be present
6. **Logistics:** Where will they be? Home, hospital, hospice? Will they want visiting nurse, chaplain?
7. **Documentation:** Order "comfort measures only"; write withdrawal protocol in chart

Withdrawal Protocol

Day of Discontinuation:

1. **Last dialysis session:** Explain to patient this is the last treatment; allow family at bedside
2. **IV access:** Reassess need for IV access; remove if not needed for comfort medications
3. **Medications:** Continue essential medications (cardiac, antihypertensive, pain control); discontinue K+ restriction or binders
4. **Labs:** Discontinue routine labs (K+, Cr, BUN, P); check only if changes management (e.g., hyperkalemia with EKG changes)
5. **Goals statement:** Document "Comfort measures only; goal is peaceful death"

Post-Withdrawal Management:

1. **Symptom assessment:** Assess pain, dyspnea, restlessness, nausea daily
2. **Medications for comfort:**
   - **Dyspnea/tachypnea:** Morphine 2–4 mg IV q2–4h PRN; titrate for relief
   - **Pain:** Acetaminophen 650 mg q6h, morphine, or fentanyl patch
   - **Nausea:** Ondansetron 4–8 mg IV q8h PRN, metoclopramide, haloperidol
   - **Restlessness/agitation:** Lorazepam 0.5–2 mg IV/PO q4–6h PRN, haloperidol
   - **Constipation:** Docusate + senna (morphine causes constipation); avoid opioid-induced ileus
   - **Dry mouth:** Oral swabs, ice chips, artificial saliva spray
3. **Fluid management:** Allow PO fluids/food as desired; no forced fluid restriction (comfort-based)
4. **Hyperkalemia:** If EKG shows peaked T-waves and patient distressed, consider calcium gluconate and insulin/glucose, but weigh burden vs. benefit
5. **Family support:** Regular updates, psychosocial support, chaplain, bereavement care offered

Expected Timeline:

- **Days 1–3:** Fatigue, mild tachycardia, slight BP elevation
- **Days 3–7:** Confusion, somnolence, decreased urine output, dehydration typical
- **Days 7–14:** Pulmonary edema, orthopnea, altered mental status, decreased responsiveness
- **Beyond 2 weeks:** Rare; usually indicates very slow decline or residual renal function

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IV. Advance Directives and Legal Documentation

Critical Advance Directive Elements for CKD Patients

Every CKD patient should have an advance directive addressing:

1. **Dialysis decision:**
   - "I want to try dialysis and see how I do" vs.
   - "I do NOT want dialysis under any circumstances" vs.
   - "Only if I remain mentally alert and physically independent"
2. **Dialysis withdrawal:**
   - "If quality of life becomes unacceptable, I want to stop dialysis"
   - "My family should make this decision if I cannot"
3. **Resuscitation:**
   - Full code (CPR, intubation, ICU) vs.
   - Limited code (no intubation) vs.
   - DNR (do not resuscitate)
4. **Other life-sustaining measures:**
   - Feeding tube decisions
   - Mechanical ventilation
   - Blood transfusions (religious considerations)
5. **Surrogate decision-maker:**
   - Identify healthcare proxy or power of attorney
   - Ensure clarity on their role and authority

State-Specific Legal Requirements

- **Living will vs. healthcare proxy:** Requirements vary by state; both recommended
- **Witness and notarization:** Most states require notarization; many allow physician attestation
- **MOLST/POLST forms:** Portable advance directive for medical orders; recommended in many states
- **Shared decision-making documentation:** Some states require specific language in charts

Updating Advance Directives

- Review at CKD diagnosis, every 12 months, at major changes in health, and before dialysis initiation
- Changes in advance directives can be made verbally and should be documented in the medical record

- Provide copies to patient, family, healthcare proxy, nephrologist, and primary care

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V. Symptom Management in Palliative CKD/ESKD

Uremic Pruritus (Renal Itch)

Epidemiology: 20–50% of ESKD patients; more severe in pre-dialysis CKD G5 and on hemodialysis

Pathophysiology: - Accumulation of uremic toxins (phosphate, histamine, substance P) - Dry skin (xerosis) from impaired sweat gland function - Secondary hyperparathyroidism (elevated PTH ☐ mast cell degranulation) - Neuropathy with abnormal sensation - Possible immunologic dysregulation

Management Ladder:

Step	Intervention	Mechanism
1	Skin care: Emollients (CeraVe, Cetaphil), avoid hot water	Decrease xerosis; hydrate stratum corneum
2	Topical: Menthol cream, capsaicin cream, tacrolimus ointment	Cooling/heat sensation; immune modulation
3	Phosphate binders (calcium-free if possible)	Reduce phosphate-associated itch
4	Optimize dialysis: Increase UFR, increase session length	Remove uremic toxins more effectively
5	Systemic: Gabapentin 100 mg TID (start low, titrate), pregabalin	GABA-ergic modulation; excellent for uremic itch
6	Antihistamines: Cetirizine 10 mg daily (non-sedating)	H1-receptor antagonism; mild effect
7	Phototherapy: Narrow-band UV-B 2–3×/week	Reduce T-cell infiltration in skin
8	Mast cell stabilizers: Tacrolimus, pimecrolimus	Block histamine release
9	Oral: Naltrexone 25–50 mg daily	Opioid receptor antagonism; emerging evidence
10	Last resort: Thalidomide 50–200 mg daily	Multiple mechanisms; high side effect profile

Palliative approach: For CKM patients nearing EOL, focus on steps 1–3 and gabapentin; avoid burdensome interventions.

Nausea and Vomiting

Etiology in CKD/ESKD: - Uremia (accumulation of toxins) - Fluid overload ☐ gastric edema - Medications (iron, antibiotics, opioids) - Gastroparesis (autonomic neuropathy) - PUD/gastritis - Hypercalcemia (hyperparathyroidism)

Management:

Cause	First-Line	Alternative
Uremic nausea	Ondansetron 4–8 mg TID, metoclopramide 10 mg TID	Dompet irone; haloperidol
Volume overload	Diuretics (if residual renal function); optimize dialysis	Fluid restriction <1 L/day
Opioid-induced	Reduce opioid if possible; add laxative	Switch to different opioid (fentanyl <morphine nausea)
Gastroparesis	Metoclopramide (enhances gastric motility)	Domperidone; ginger
PUD/Gastritis	PPI, H2-blocker; reduce NSAIDs	H. pylori testing/treatment if positive

Palliative approach: Ondansetron is generally well-tolerated; allow dietary flexibility; small, frequent meals if able to eat.

Pain Management

Pain in CKD/ESKD sources: - Bone/joint pain (secondary hyperparathyroidism, renal osteodystrophy) - Muscle cramps (electrolyte imbalance, uremia, dialysis-related) - Neuropathic pain (uremic neuropathy, diabetic neuropathy) - Vascular access pain (dialysis) - Visceral pain (PUD, pancreatitis, renal infarction)

Opioid Dosing in CKD:

Opioid	eGFR <30	Action
Morphine	Accumulates; 25–50% dose reduction	Renally cleared; avoid high doses; consider alternatives
Codeine	Avoid	Toxic metabolite accumulation
Hydromorphone	Acceptable; renally cleared but shorter-acting than morphine	Start low (0.5–1 mg q6–8h); monitor for overdose
Fentanyl	Safe; hepatic metabolism	Preferred for CKD; transdermal preferred; titrate carefully
Methadone	Use with caution	Variable clearance; QT prolongation risk; specialized dosing needed

Non-opioid pain management: - Acetaminophen: Safe (no accumulation); use <3 g/day in CKD - NSAIDs: **Avoid** in all stages of CKD - Gabapentin: Start 100 mg TID, titrate up; accumulates—reduce dosing if eGFR <30 - Pregabalin: Safer than gabapentin in CKD (less accumulation); start 25 mg daily - Topical: Lidocaine patches, capsaicin cream for localized pain

Muscle Cramps (Dialysis-Related Leg Cramps)

Etiology: Electrolyte imbalances (Na, K, Ca, Mg), intradialytic hypotension, uremia

Management:

1. **Prevention during dialysis:**
   - Avoid rapid ultrafiltration; use linear UF
   - Maintain Na+ gradient (dialysate Na 138–140 mEq/L)
   - Warm blanket during session
   - Adequate analgesia before dialysis
2. **Acute treatment:**
   - Stretch affected muscle
   - Hypertonic saline (3% NaCl 50 mL slow IV) for severe cramp
   - Massage
3. **Chronic prevention:**
   - Vitamin E 400 IU daily (some evidence)
   - Quinine sulfate 260 mg QHS (controversial; tinnitus, QT risk)
   - **Avoid:** Statins, diuretics if possible (worsen cramps)
   - Optimize magnesium (Mg target 1.8–2.4 mg/dL during dialysis)
   - L-carnitine supplementation (controversial; some patients report benefit)

Restless Leg Syndrome in CKD

Etiology: Uremia, iron deficiency, nerve damage, phosphate accumulation, dopamine dysfunction

Management:

Stage	Intervention
1	Iron supplementation if ferritin <200 or TSAT <20%
2	Optimize dialysis; improve anemia (Hgb target 10–11)
3	Gabapentin 300–900 mg TID or pregabalin 150–600 mg daily
4	L-dopa/carbidopa for breakthrough symptoms
5	Dopamine agonists (ropinirole, pramipexole) if refractory—use cautiously in CKD

Palliative approach: Gabapentin is excellent and generally well-tolerated; encourage leg stretching, warm baths, massage.

Fatigue and Weakness

Etiology: Anemia, uremia, malnutrition, muscle loss, depression, inadequate dialysis

Management:

1. **Optimize hemoglobin:** Target 10–11 g/dL; higher targets don't improve symptoms and increase CV risk
2. **Nutritional support:** Adequate protein (0.8–1.0 g/kg), phosphate control, fluid balance
3. **Physical activity:** Encourage walking, gentle exercises, resistance training if able

4. **Screen and treat depression:** PHQ-9; SSRI if depressed
5. **Medications:** Avoid sedating drugs (antihistamines, anticholinergics); continue stimulants cautiously
6. **Optimize dialysis:** Increase session length or frequency if inadequately dialyzed

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VI. Validated Assessment Tools for Palliative CKD

IPOS-Renal (Integrated Palliative Care Outcome Scale — Renal Version)

Measures symptom burden and quality of life in ESKD patients:

Item	Scale	Target
Pain	0–4 (none to overwhelming)	<2 (mild or none)
Shortness of breath	0–4	<2
Nausea	0–4	<2
Constipation	0–4	<2
Diarrhea	0–4	<2
Pruritus	0–4	<2
Fatigue	0–4	<2
Lack of appetite	0–4	<2
Feeling depressed	0–4	<2
Anxiety	0–4	<2
Feeling at peace	0–4	>3 (at peace most/all of the time)
Life worthwhile	0–4	>3
Dealing/coping	0–4	>3

Administration: Monthly; triggers intervention if score >2 for any symptom or <3 for wellbeing items.

ESAS-Renal (Edmonton Symptom Assessment Scale — Renal)

Simpler symptom checklist (0–10 scale): - Pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well-being, breathlessness, restlessness

Use: Weekly self-report; identifies worst-controlled symptom for intervention focus.

Palliative Prognostic Index (PPI)

Predicts survival in advanced disease:

Indicator	Score
KPS <50%	4 points
Oral intake poor	2 points
Edema present	1 point
Dyspnea at rest	3 points
Delirium/altered mental status	4 points

Indicator	Score

- **Score <6:** Median survival 11+ weeks
- **Score 6–8:** Median survival 4 weeks
- **Score >8:** Median survival 1 week

VII. Estimating Survival Without Dialysis

Natural History of CKD G5 (eGFR <15) Without RRT

eGFR at Diagnosis	Median Survival	Factors Worsening Survival
10–15	6–24 months	Age >75, diabetes, CHF, low albumin
5–10	3–12 months	Rapid decline, symptoms, comorbidities
<5	1–6 months	Terminal illness, severe frailty, sepsis

Clinical Prognosticators in CKM

Poor prognostic factors (suggest <6 months survival): - Age >80 - eGFR decline >4 mL/min/year - Baseline albuminemia <3.5 g/dL - Uncontrolled hypertension (SBP >160) - Advanced malignancy or cardiac disease - Cognitive decline or frailty (CFS >6) - Multiple comorbidities (Charlson score >5) - Anemia (Hgb <9) unresponsive to iron/ESA - Depressed mood or social isolation

Favorable prognostic factors (longer survival possible): - Age 65–75 - eGFR decline 1–2 mL/min/year - Albumin >3.8 g/dL - Good functional status (independent ADLs) - Preserved appetite and oral intake - Single major comorbidity (well-controlled) - Supportive family

Survival Comparison: CKM vs. Dialysis

Realistic Expectations by Scenario:

Patient Profile	CKM Median Survival	Dialysis Median Survival	Palliative Advantage
Age 75, robust, single comorbidity	18–24 months	36–48 months	Dialysis preferred if willing
Age 80, frail, multiple comorbidities	8–12 months	12–18 months	CKM + earlier palliative care may optimize QoL
Age 85+, dependent ADLs, dementia	4–8 months	6–12 months	CKM strongly preferred

Patient Profile	CKM Median Survival	Dialysis Median Survival	Palliative Advantage
Advanced cancer + ESKD	2–6 months	3–9 months	CKM eliminates dialysis burden; focus on comfort
Severe CHF EF <20% + ESKD	3–8 months	6–12 months	High mortality on both; CKM reduces complications

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VIII. Special Populations in Palliative CKD

Dementia and Cognitive Decline

- Capacity for decision-making often diminishes with dementia
- Advance directives should ideally be completed **before** cognitive decline
- If no advance directive: Apply substituted judgment (what patient would want if able to decide) or best interest standard
- Generally, **no dialysis** is recommended in moderate-to-severe dementia (patient cannot communicate preferences, understand treatment, comply with diet/restrictions)
- Palliative care appropriate; focus on comfort, dignity, family presence

Diabetes and CKD/ESKD

- Diabetes accounts for 40% of ESKD cases
- Median survival on dialysis in diabetic ESKD: 24 months vs. 60 months non-diabetics
- Glycemic targets in ESKD: Less stringent (A1c 7–8%); hypoglycemia risk high with reduced renal clearance
- Insulin dosing: 25–50% reduction in CKD G5; careful monitoring essential
- Palliative approach appropriate in many diabetics with ESKD + comorbidities

Palliative Care in Pediatric CKD

- Generally rare to pursue CKM (goal is transition to adulthood on dialysis/transplant)
- Exception: Infants with severe bilateral renal hypodysplasia and predicted ESKD in first year of life
- Discussion of goals-of-care should include quality of life, family wishes, and realistic transplant timeline
- Palliative care supports but does not replace dialysis in most pediatric cases

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Practice Questions

1. **An 82-year-old man with CKD G5 (eGFR 8), diabetes, and CHF (EF 25%) is referred for dialysis evaluation. He lives alone, is mostly homebound, and his**

daughter expresses concern about quality of life. The Surprise Question is answered: "No, I would not be surprised if he died within 12 months." Which is the BEST next step?

- A) Emergently place a dialysis catheter and start urgent hemodialysis
- B) Discuss conservative management as primary option; frame as maintaining quality of life and autonomy at home
- C) Tell him he should go on dialysis because it's standard of care
- D) Refer to hospice only; discontinue all medical care

Answer: B. This patient has poor prognostic indicators (age >80, low EF, functional decline, positive Surprise Question suggesting <12 months median survival). Conservative management focusing on symptom control, home-based care, and quality of life is the most appropriate first discussion. If he chooses dialysis despite these factors, support that choice, but he should understand realistic expectations (likely shorter survival than in dialysis candidates without CHF/advanced age).

2. **A 68-year-old woman on hemodialysis for 3 years develops progressive weakness, loss of appetite, and cognitive decline. Her husband reports she now spends most days in bed and has stated "I don't want to keep doing this." She stops coming to dialysis sessions. After ensuring she understands the consequences (death within 2–3 weeks), you discuss comfort measures. Which medication is NOT appropriate for symptom management after dialysis withdrawal?**

   - A) Morphine for dyspnea and anxiety
   - B) Ondansetron for nausea
   - C) Aggressive diuretics to lower K+ and manage fluid overload
   - D) Gabapentin for agitation/restlessness

   Answer: C. After dialysis withdrawal, the goal shifts entirely to comfort. Aggressive interventions like diuretics to manage hyperkalemia or fluid overload prolong dying and cause distress. If hyperkalemia causes EKG changes and distress, calcium gluconate and insulin/glucose can be considered, but routine electrolyte management is inappropriate. Morphine, ondansetron, and gabapentin are all excellent comfort measures.

3. **You are counseling a 74-year-old woman with newly diagnosed CKD G5 (eGFR 12) and albuminemia 3.2 on the choice between conservative management vs. dialysis. She is independent, has one daughter nearby, and her 72-year-old husband has similar functional status. She asks: "How long will I live if I don't do dialysis?" Which response is most honest and helpful?**

   - A) "You'll die within 3 months; you need dialysis now"
   - B) "Median survival without dialysis in someone like you is about 18–24 months, but could range from 12–36 months depending on how your kidney function declines and other health events. On dialysis, median survival might be 36–48 months, though again with wide variation"
   - C) "No one can predict, so just try dialysis for a month and see how you feel"
   - D) "If you don't do dialysis, you'll die of uremia; dialysis is your only option"

   Answer: B. This patient has more favorable prognostic factors (age 74, independent, single comorbidity). Honest prognostication should include: (1) median survival estimates with

ranges; (2) acknowledgment of uncertainty; (3) comparison of both paths; (4) emphasis on individual variation. She can then make an informed choice aligned with her values.

Clinical Pearls Summary

- **Conservative management is not "doing nothing."** It's proactive symptom management + renoprotection + advance care planning.
- **The Surprise Question predicts mortality better than many objective measures.** Use it to guide care intensity.
- **Dialysis withdrawal is ethical, legal, and common.** Support it compassionately with robust palliative care.
- **Goals-of-care conversations are separate from treatment decisions.** Discuss values first, then decide on dialysis vs. CKM.
- **Palliative IPOS-Renal and ESAS-Renal identify undertreated symptoms.** Use them monthly.
- **Opioid dosing is safe in CKD when adjusted.** Fentanyl > morphine in advanced CKD; avoid codeine.
- **Uremic pruritus responds well to gabapentin.** Often overlooked but highly distressing.
- **Survival without dialysis averages 18–24 months in robust elderly**, but can be much shorter with frailty/comorbidities.

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