EDITOR'S INTRODUCTION

HIGH-QUALITY PATIENT CARE PATHWAYS ARE CENTRAL TO THE ESTABLISHMENT OF PERITONEAL DIALYSIS

High-quality health care requires responsive patient pathways, and one of the challenges of establishing patients on peritoneal dialysis (PD) is that such pathways are easily fractured. Such fracturing was demonstrated in the IDEAL study (1), in which patients who were randomized to start PD later in the course of their chronic kidney disease (5 – 7 mL/min) were less likely to actually be established on PD therapy (they were more likely to receive hemodialysis) than were those who were randomized to start PD earlier (10 – 14 mL/min).

In this issue of *Peritoneal Dialysis International* (PDI), a detailed paper by Peter Blake and colleagues describes 6 important steps in the PD care pathway, ranging from identification of potential patients, to eligibility assessment, offering PD as a modality, patient choice, catheter insertion, and commencement of PD. The authors illustrate how barriers at each stage can impair the likelihood of patients being ultimately established on their chosen therapy. Their work was facilitated through the use of a bespoke web-based software platform.

Optimal pre-dialysis care involves the careful decision-making support necessary to provide patients and their families with the opportunity to choose a renal replacement therapy that best fits with their individual preferences and attributes. The wide variation in the uptake of PD internationally and within countries suggests that patients do not always have that opportunity. A qualitative paper from Singapore (Konstadina Griva and colleagues) explores the factors that influence decision-making in that community. Barriers to PD included fears about infection and the level of commitment required to perform exchanges—barriers that were often based on misperceptions. Importantly, the views of other patients were also influential. The authors conclude that providing clear, well balanced information about dialysis modalities is essential if patients are to be able to make a systematic decision about their most appropriate treatment choice.

In several areas of the world, the possibility of providing PD supported by paid assistants has increased the versatility of the therapy. In a paper from Rio de Janeiro, Marcia Franco and colleagues describe their experience of automated PD in which assistance by a nurse or family member is provided to elderly patients with combinations of physical or cognitive debilities that leave them unable to perform their own PD. The initiative was found to be an effective homecare alternative, with acceptable outcomes, including peritonitis and patient survival rates. In an accompanying commentary, Matthew Oliver concludes that assisted PD provides an opportunity to expand patient choice, both in developing and in richer health care economies.

Also in this issue, Man-Wai Lo and colleagues from Hong Kong report an association between the use of gentamicin cream as exit-site prophylaxis and the isolation of atypical *Mycobacterium* species from the exit site in 9 patients. The routine use of exit-site prophylaxis is an important part of the strategy to reduce exit-site and peritonitis rates, and yet clearly, concerns from many quarters are being raised about the emergence of resistant organisms. Given this most recent report, the renal community needs to maintain an elevated level of clinical awareness. As a consequence of such concerns, a new multifaceted antimicrobial resistance strategy and action plan has been launched in the United Kingdom, tackling themes that include evidence-based prescribing, infection prevention, public awareness, innovative research, and importantly, international collaboration (2). Of course such international collaboration is central to the ethos of our journal.

As pressure rises for space in PDI, one strategy the editorial board is planning is to move some material to electronic-only publication. With the support of our publisher, Multimed Inc., we will start with publication of letters to the editor in an online-only version from 2014, and in due course, supportive material to original

articles can also be presented in this way, including detailed methods and supplementary tables. This change will allow for more effective use of the pages available in PDI, with the instructions for authors being revised accordingly. If you have views about this initiative, why not share them with me directly?

Martin Wilkie
Editor-in-Chief

REFERENCES

1. Johnson DW, Wong MG, Cooper BA, Branley P, Bulfone L, Collins JF, *et al.* Effect of timing of dialysis commencement on clinical outcomes of patients with planned initiation of peritoneal dialysis in the IDEAL trial. *Perit Dial Int* 2012; 32:595–604.
2. Kessel AS, Sharland M. The new UK antimicrobial resistance strategy and action plan. *BMJ* 2013; 346:f1601.