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Renal transplant failure has a devastating impact requiring greater recognition and support

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Context

Four per cent of US patients who started dialysis in 2007 did so because of a failed transplant.¹ Although in many instances loss of graft followed a chronic course, in some cases the process was more subacute, taking place over weeks to months. There is limited research examining how patients with a failed or failing graft cope during a potentially tumultuous transition and the impact of graft loss on dialysis re-entry and psychosocial support. This paper attempts to address some of these research gaps.

Methods

Sixteen participants (including patients as well as 'significant others') were recruited from one regional transplant centre comprising three district-level hospitals. Three semistructured interviews were conducted within 1 year postgraft failure. The interview included open-ended questions with follow-up details when appropriate. Analysis consisted of the identification and interpretation of themes, following a three-step phenomenological, hermeneutic method.

Participants were approached via purposive invitations. The authors report a predominance of patients in the study had renal failure due to polycystic kidney disease (PCKD). PCKD is unique in that it is largely hereditary thus conferring specific psychological, medical and social needs throughout a person's lifespan as compared to other causes of renal failure.² Thus, the study group is highly selective, introducing significant potential for bias in participants' perspectives. In addition, allowing a 'swap' of which family member was to represent the patient's 'significant other' introduced inconsistency of inclusion criteria (ie, the mother of a patient stepped in to fill this role when the significant other was at work). Lastly, little information is provided about who coded transcripts, or exactly how this was done. This leaves us without a good sense of coding application process and consistency between members of the research team.

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Competing interests None.

Findings

Patients in the study seemed to support perspectives in-line with well-established facts about transplantation. Transplantation offers the highest quality of life of all the renal replacement modalities and makes life seem 'normal' again. Interestingly, despite underlying awareness of limited transplant lifespan, denial was commonly cited as a coping mechanism to avoid anxiety. Potentially, this explains the sense of shock patients felt when learning about the loss of their transplant and the need to start dialysis.

A tremendous insight from this study is the perception of participants about the emotional toll from their loss, which is left largely unacknowledged by the medical team. Some patients even described a sense of being left to cope on their own during the transition from graft failure to dialysis. Spouses felt this acutely as well, attempting to balance their role of supporter, while struggling with the mental and physical toll this had on their partners. Perhaps this was made even more difficult with lack of acknowledgement by medical personnel. It made the process of grieving 'illicit' and the authors use the term 'disenfranchised grief' to describe this phenomenon.

On a positive note, although participants described being left emotionally adrift in some aspects, their overall views of care provided were generally positive.

Commentary

How justified are these findings and what are the implications for the care of these patients? It is important to bear in mind that qualitative interpretation of data may be subject to prior work by the research team. The authors point out a potential for this in their introduction, at least peripherally. However, it is a potential limitation that they did not list. Still there are valuable insights from this research.

Identifying patients' fear of being left isolated from medical staff during their graft loss is important. It is possible that healthcare personnel may not be able to totally empathise with the loss or that they view this as a natural ending to a 'good run with a transplant kidney'. Either way, this needs to change.

Transplantation offers hope and better outcomes for patients, but healthcare providers must proactively engage patients and their social support/life partners early. Interventions are needed to better prepare and support patients for the transition to dialysis or an additional transplant in the future. These interventions must empower patients to deal with these issues using trained transplant personnel to create a balance between graft loss and a life to be lived fully and with hope for a good future.

References

1. U.S. Renal Data System. USRDS 2009 annual data report: atlas of chronic kidney disease and end-stage renal disease in the United States. Bethesda: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2009.
2. Gabow PA. Autosomal dominant polycystic kidney disease. N Engl J Med. 1993; 329:332–42. [PubMed: 8321262]

Implications for practice and research

- Patients returning to dialysis after transplant failure need social support to deal with this loss.
- The best intervention to address the feeling of isolation needs further study.