

Debunking Ten Myths About Kidney Supportive Care

Lai, Yong Chang¹, Theivendran, Thiveya^{1,2,3} and So, Sarah^{1,3}

¹ Nepean Research Kidney Centre, Department of Renal Medicine, Nepean Hospital, Kingswood, NSW, Australia

² School of Medicine, Western Sydney University, Sydney, New South Wales, Australia

³ Faculty of Health and Medicine, University of Sydney, Sydney, New South Wales, Australia

Corresponding Author

Yong Chang Lai

Address: Department of Renal Medicine, Nepean Hospital, Derby Street, Kingswood, NSW 2747

Phone Number: (02) 4734 2000

Email: YongChang.Lai@health.nsw.gov.au

ABSTRACT

Kidney supportive care (KSC) is a core component of integrated care for people with kidney failure; yet misconceptions about KSC may impede prompt referral and implementation in routine nephrology practice. Although some practitioners may still assume KSC only comprises end-of-life care, KSC can improve quality of life at any stage of chronic kidney disease (CKD), by addressing symptom burden, supporting shared decision-making and advance care planning, and providing psychosocial support without compromising patients' values and treatment goals. It is not limited to only patients who are dying and may include patients actively receiving dialysis and kidney transplantation. This article discusses ten common myths about KSC: (1) KSC and conservative kidney management (CKM) are synonymous; (2) KSC is appropriate only in end-of-life care; (3) dialysis increases survival for all patients; (4) choosing conservative kidney management means we do not provide any further medical care; (5) asymptomatic patients do not need supportive care; (6) advance care planning is solely the responsibility of KSC; (7) all CKD-associated pruritus is due to elevated phosphate; (8) there are no options for pain management in ESKD; (9) dying from ESKD is always a "gentle death" and (10) nephrologists have little role in managing patients receiving CKM. We hope that by addressing these common misconceptions we can empower all nephrology care providers to incorporate KSC principles into daily practice and encourage early and appropriate referrals to KSC.

Keywords: kidney supportive care, renal supportive care, symptoms, end of life care, quality of life

INTRODUCTION

Kidney Supportive Care (KSC), formerly known as Renal Supportive Care, is a treatment approach that aims to improve the quality of life for people living with chronic kidney disease (CKD) and their families.(1) KSC is now recognised as an essential component of integrated care for people with CKD. Delivery of KSC occurs within a multidisciplinary framework consisting of both medical and allied health practitioners and includes integration with community services. It embodies components of shared decision-making, symptom management, advance care planning, and spiritual care.(2) We hope to empower nephrologists to incorporate KSC principles within their day-to-day nephrology practice by addressing common myths pertaining to KSC.

MYTH 1: Kidney Supportive Care is the same as Conservative Kidney Management (CKM)

KSC and conservative kidney management (CKM) are not synonymous terms and should not be used interchangeably.

KSC embodies a holistic approach to caring for people with CKD and incorporates elements of palliative care into routine nephrology practice, including early recognition and management of physical, psychological, social, and spiritual concerns. Core elements of KSC also involve discussion of prognosis, shared decision-making, and advance care planning, with the primary goal to improve quality of life. Importantly, KSC is not limited to any treatment modality. It can be provided alongside disease-modifying therapy, dialysis, or kidney transplantation, and remains relevant throughout the CKD trajectory rather than only at the end of life. (1, 2)

CKM, by contrast, is a defined treatment pathway for people with advanced kidney failure who choose not to undergo dialysis, or for whom dialysis is unlikely to provide benefit. CKM focuses on improving quality of life through medical management of kidney disease and its complications, including fluid balance, anaemia, hypertension, CKD-mineral and bone disorder, and pain, as well as slowing progression if consistent with the patients' goals.(2, 3) This pathway would include end-of-life care as kidney failure eventually progresses to the final, terminal stages.

This distinction matters because it shapes referral pathways and treatment goals. All patients managed with CKM should receive KSC, since symptom management, psychosocial support, and advance care planning are inseparable from CKM. The reverse, however, is not true: patients on dialysis or living with a transplant may have substantial symptom burden, treatment burden, and psychosocial needs — and require KSC — without being on the CKM pathway.(1, 2) In modern nephrology, kidney supportive care is an inseparable part of clinical practice and should be “every nephrologist's business”.(1)

MYTH 2: KSC is only for dying patients

KSC is not synonymous with end-of-life care. Historically, KSC was provided by palliative care physicians working collaboratively with renal services and provided end-of-life care for people withdrawing from dialysis or dying with their kidney condition, alongside symptom management. Today, it is understood that KSC has a broader role, and should be offered to people with kidney disease according to need rather than referring purely based on prognosis or treatment pathway.(1, 3)

KSC can be provided at any stage of chronic kidney disease and simultaneously with disease-modifying and life-extending interventions such as haemodialysis, peritoneal dialysis, and kidney transplant. KSC is a complementary service that addresses issues that are often not identified in routine care, such as trouble symptoms, psychological distress, serious illness communication, shared decision-making, advance care planning, providing caregiver support, and coordinating with community and palliative care services when necessary.(2, 3)

Importantly, referral to KSC does not mean that there is no ongoing active treatment or potential consideration of kidney replacement therapy. Kidney transplant candidates, for instance, can face multiple physical symptoms, such as fatigue, itching, pain, or psychological distress while waiting for transplantation. These can be addressed through KSC without excluding them from transplant candidacy. Furthermore, patients who are already transplanted may continue to suffer symptoms such as pain, fatigue, sleep disturbances, or nausea. Similarly, KSC is also available to dialysis recipients who wish to engage in symptom optimisation and advance care planning while maintaining life-sustaining treatment. (1, 3)

Considering KSC as a part of routine nephrology care also facilitates discussions about values, preferences, and goals of treatment for the patient. Conducting these conversations early gives patients and their families the opportunity to make well-considered choices ahead of time. This approach aligns with the broader transition from disease-centred care to a person-centred approach in nephrology, considering both longevity and quality of life.(1, 3)

MYTH 3: Dialysis will prolong life in all patients with end-stage kidney disease

Whilst dialysis can be a life-sustaining treatment, it is not necessarily life-prolonging in all patients with kidney failure. The decision for CKM is often explained by a focus on quality rather than quantity of life. However, increasing evidence suggests that dialysis itself does not offer a survival advantage in patients of older age, multiple comorbidities, and poor functional status.(4) In patients aged > 80 years or in patients aged >75 years with severe comorbidity, there is no significant survival advantage offered by dialysis.(4) Such patients would not experience a significant benefit and would instead face potential harm with KRT should be identified and offered CKM.

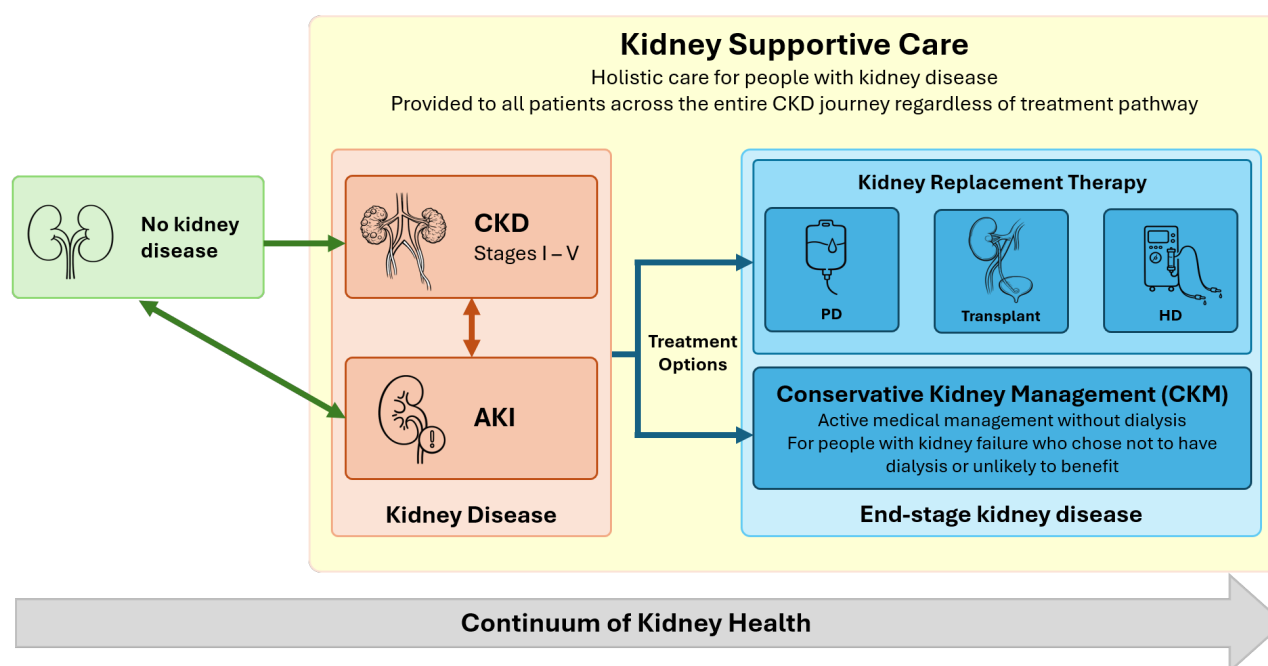


Figure 1. Kidney supportive care across the CKD continuum. KSC is provided throughout the CKD journey irrespective of treatment modality. CKM represents one management pathway for patients with advanced kidney failure, for selected patients with kidney failure who are not planned for to receive kidney replacement therapy.

MYTH 4: No dialysis means you will be left to die

Electing CKM does not mean abandoning treatment, nor does it mean death is imminent. CKM may have advantages for those patients who prioritise independence, quality of life, and wish to avoid the treatment and logistical burdens associated with kidney replacement therapy. One study has shown that in patients aged > 70 years, those receiving dialysis reported increased treatment burden and experienced less time away from the hospital, with only 282.7 hospital-free days per year, compared to those receiving CKM, who had 352.7 hospital-free days per year.⁽⁴⁾ Furthermore, most people receiving CKM live for months to years with kidney failure whilst receiving active, nuanced care. This includes renoprotective interventions to slow the progression of kidney disease and optimise long-term outcomes.⁽²⁾ There is a careful balance of managing the symptoms and complications of kidney failure, with a focus on optimising functional capacity and quality of life.⁽²⁾ This is underpinned by a strong understanding of the patient's priorities and physical, psychosocial, and spiritual needs, which may change as the CKD progresses, and would include transitioning to an end-of-life phase of care when the time comes.⁽²⁾

MYTH 5: Asymptomatic patients don't need supportive care - "If they're not complaining, they have no symptoms"

The symptom burden experienced by people living with kidney disease has historically been under-recognised. Many patients experience multiple symptoms yet will disclose them only if prompted. In general, fatigue, pruritus, pain, sleep disturbances, anxiety, and depression tend to be viewed by patients as an

inherent part of kidney disease or aging, while clinicians may tend to focus more on biochemical markers and disease progression.⁽⁵⁾

There is growing awareness that systematic symptom assessment should be a key component of the care of CKD patients, including for those receiving dialysis. The International Society of Peritoneal Dialysis (ISPD) recommends the routine use of patient-reported outcomes among peritoneal dialysis patients, with the first practice recommendation emphasising optimisation of patients' quality of life alongside symptoms and treatment burden.⁽⁶⁾ This recognises that traditional indicators of clinical outcomes do not always cover the aspects that patients consider important.

Symptom burden is not exclusive to dialysis patients. Despite great improvement in survival and quality of life provided by kidney transplantation, kidney transplant recipients still suffer from many physical and psychological symptoms, with psychological burden being comparable to that reported by patients on dialysis.⁽⁷⁾ Fatigue, sleep disturbance, gastrointestinal symptoms, pain, sexual dysfunction, and psychological distress remain common after transplantation. Similarly, survivors of acute kidney injury, a group historically overlooked for KSC needs, may experience symptom and treatment burdens similar to those of patients living with established chronic kidney disease.⁽⁸⁾

For this reason, Kidney Supportive Care places considerable emphasis on routinely asking patients about their symptoms rather than waiting for them to raise concerns. Patient-reported outcome measures, such as IPOS-Renal and EQ-5D-5L, are used

in routine clinical practice to systematically assess symptom burden.(3) Clinical priorities may differ significantly between physician and patient.

MYTH 6: All discussions about advance care planning and death should be referred to the KSC.

Providing holistic care for patients with CKD is far more than monitoring kidney function alone. Whilst physicians are comfortable and confident in managing the core elements of CKD such as blood pressure, anaemia, fluid status, and kidney replacement therapy, navigating grey areas such as death, dying, and advance care planning may be considered more challenging. Delivering truly holistic care within a culture of shared decision-making means helping patients and families understand what lies ahead as kidney or other organ function declines. Furthermore, nephrologists' familiarity with the trajectory and complications of dialysis and transplantation also positions them well to judge when the time has come to discuss discontinuing kidney replacement therapy.(1) The ISN's recent outline of the core nephrologist skillset highlights the ability to communicate, counsel, prognosticate, and discuss advance care planning as essential competencies, leading to growing recognition that training programs must build this capability explicitly.(2)

The long-term nephrologist-patient relationship carries a depth of trust and continuity that is difficult for any other clinician to replicate on short notice. Even in KSC, overall direction and goals of care are often led by the primary nephrologist. Delegating all ACP discussions to KSC could result in delayed discussions, as well as diminish opportunities for integrating patient values into regular nephrology consultations. Although the involvement of specialist palliative care clinicians, being better trained in serious illness communication, plays an important role in supporting ethically or clinically complex cases such as unresolved family conflict or prognostic uncertainty, for most goals-of-care discussions, the nephrologist's existing relationship and clinical knowledge outweigh the benefit of communication training from a new care provider (the KSC team).

MYTH 7: All CKD-associated pruritus is due to elevated phosphate

CKD-associated pruritus is highly prevalent and distressing for patients, and contributes to restlessness, poor sleep, agitation, and depression. Affecting over 38% of patients receiving haemodialysis and 28% of patients on peritoneal dialysis, CKD-associated pruritus is associated with higher risks of hospitalisations, missing sessions, withdrawal from dialysis, and death (9,10). Multiple studies have demonstrated that the pathophysiology of pruritus is unclear and is driven by mechanisms beyond simply hyperphosphatemia, hyperparathyroidism, or uraemia alone (10). First-line therapeutic interventions include skin emollients, avoidance of hot water baths, and pharmacotherapy including gabapentin and pregabalin.

The introduction of difelikefalin, a selective kappa opioid receptor agonist, has revolutionised our ability to treat moderate to severe itch in patients on dialysis. However, it may be underutilised, given the systemic under-recognition and reporting of pruritus symptoms (10).

MYTH 8: Nothing can be given for pain if you have end-stage kidney failure

Managing pain in patients with CKD requires attention to understanding the aetiology and chronicity of pain, with the goal of preserving comfort, functional ability, and quality of life. Guidelines for the pharmacological management of pain in patients with advanced CKD do exist. For nociceptive pain, suggested regimens include regular paracetamol with or without the addition of a stronger opioid. Opioid options include buprenorphine or hydromorphone for more severe pain. (11) For neuropathic pain, therapies include gabapentin or pregabalin as first line, and further-line agents such as carbamazepine or tricyclic antidepressants.(11)

MYTH 9: Dying from kidney failure is always a "gentle death"

It is commonly assumed that death from kidney failure is peaceful, based on the premise that progressive uraemia leads to increasing drowsiness and an eventual, quiet loss of consciousness. Although this trajectory is observed in some patients, it should not be assumed that dying from kidney failure is always comfortable or symptom-free.

Longitudinal data from patients with stage 5 CKD managed without dialysis demonstrate a considerable symptom burden in the final weeks of life. Patients reported a median of 16.6 symptoms (range 6–27), with common symptoms including fatigue, pruritus, dyspnoea, pain, nausea, anorexia, and oedema. Symptom prevalence and severity increased as death approached and, in some domains, exceeded that reported in patients with advanced cancer. (12) These symptoms reflect not only uraemia but also fluid overload, electrolyte disturbances, and coexisting illness.

This does not mean that death from kidney failure must be distressing. Rather, it highlights the importance of Kidney Supportive Care (KSC). Through systematic symptom assessment, optimisation of CKD management, anticipatory prescribing, psychosocial support, advance care planning, and timely involvement of specialist palliative care when appropriate, KSC aims to minimise suffering and optimise quality of life throughout the illness trajectory, including the final stages of life.(2) A peaceful death should therefore not be presumed as the natural course of kidney failure, but as the result of proactive, patient-centred care.

MYTH 10: Nephrologists have nothing to add to conservative kidney management

Some nephrologists may feel that choosing CKM marks the end of specialist nephrology care. In reality, CKM remains an active model of care in which evidence-based nephrology management is delivered alongside the principles of kidney supportive care (KSC).(2) Patients receiving CKM still require ongoing optimisation of fluid overload, treatment of their hyperkalaemia and metabolic acidosis where appropriate, management of complications such as hypertension, chronic kidney disease–mineral and bone disorder; and regular review of their medication-related side effects. As kidney function declines, treatment should be individualised according to prognosis, symptom burden, and the patient's goals of care. What changes is not whether treatment is provided, but how it is provided, with greater emphasis on interventions that offer meaningful clinical or quality of life benefit while minimising treatment burden.(2)

Within CKM, the principles of KSC underpin routine nephrology care through proactive symptom assessment and management, psychosocial support, shared decision-making, and advance care planning.(1) Consequently, CKM should not be regarded as the withdrawal of active treatment, but as a shift in therapeutic priorities from kidney replacement therapy towards preserving quality of life while ensuring that care remains aligned with the patient's values and goals. The role of the nephrologist therefore evolves rather than diminishes, remaining central to coordinating comprehensive, person-centred care throughout the course of advanced kidney disease. (Figure 2).(1)

Figure 2. Simple ways to integrate KSC into practice

Simple ways to integrate KSC into practice
1. Symptom screening should be proactive and structured, rather than reliant on patient's volunteering complaints.
2. Referral to KSC should be triggered by need, including unmet symptom, psychosocial, or decision-making needs, rather than by prognosis or treatment pathway.
3. Conversations about prognosis and advance care planning should generally be led by the primary nephrologist, with KSC engaged as a collaborator for the most complex or difficult cases, rather than a default referral point.

CONCLUSION

KSC is now recognised as a vital component of integrated kidney care — not a service reserved for end-of-life scenarios. Misconceptions about KSC can delay referral, limit options for symptom management and shared decision-making, and contribute to fragmented care. Recognising KSC as a complement to disease-focused care at every stage of CKD helps meet patients' and families' needs across the biological, psychological, social, and spiritual domains. Our hope is that addressing these myths can empower nephrologists to integrate KSC concepts into their everyday care.

ACKNOWLEDGEMENTS

The authors wish to thank the members of the Kidney Supportive Care Special Interest Group for their myth suggestions.

REFERENCES

1. Brown MA, Hole BD, Brennan F, Vallath N, Davison SN. Kidney supportive care: every nephrologist's business. *Kidney International*. 2025;107(4):582-6. doi: 10.1016/j.kint.2025.01.010.
2. Davison SN, Pommer W, Brown MA, Douglas CA, Gelfand SL, Gueco IP, et al. Conservative kidney management and kidney supportive care: core components of integrated care for people with kidney failure. *Kidney Int*. 2024;105(1):35-45. doi: 10.1016/j.kint.2023.10.001. PubMed PMID: 38182300; PubMed Central PMCID: PMC12439246.
3. Ducharlet K, Brennan F, Raj R, Ogivly C, Stallworthy E, Li KC, et al. Kidney supportive care in Australia and New Zealand: an Australian and New Zealand Society of Nephrology (ANZSN) and Australian and New Zealand Society of Palliative Medicine (ANZSPM) guidance document. *Internal Medicine Journal*. 2026;56(S2):4-48. doi: <https://doi.org/10.1111/imj.70463>.
4. Verberne WR, Dijkers J, Kelder JC, Geers ABM, Jellema WT, Vincent HH, et al. Value-based evaluation of dialysis versus conservative care in older patients with advanced chronic kidney disease: a cohort study. *BMC Nephrol*. 2018;19(1):205. Epub 20180816. doi: 10.1186/s12882-018-1004-4. PubMed PMID: 30115028; PubMed Central PMCID: PMC6097302.
5. Siriwardana AN, Hoffman AT, Brennan FP, Li K, Brown MA. Impact of Renal Supportive Care on Symptom Burden in Dialysis Patients: A Prospective Observational Cohort Study. *J Pain Symptom Manage*. 2020;60(4):725-36. Epub 20200507. doi: 10.1016/j.jpainsymman.2020.04.030. PubMed PMID: 32389605.
6. Brown EA, Blake PG, Boudville N, Davies S, de Arteaga J, Dong J, et al. International Society for Peritoneal Dialysis practice recommendations: Prescribing high-quality goal-directed peritoneal dialysis. *Perit Dial Int*. 2020;40(3):244-53. Epub 20200121. doi: 10.1177/0896860819895364. PubMed PMID: 32063219.
7. Hu K, Yuan L, Xue C, Xu J, Tian S, Mao Z. The Influence of Different Kidney Replacement Modalities on Health-Related Quality of Life in Patients with ESKD. *Kidney360*. 2025;6(11):1939-47. Epub 20250620. doi: 10.34067/kid.00000000844. PubMed PMID: 40540355; PubMed Central PMCID: PMC12626664.
8. Huang F, Ethier I, Vaillant I, Silver SA, Côté J-M. Self-Reported Burden and Health-Related Quality of Life in Acute Kidney Injury Survivors Compared with Patients with Advanced CKD. *Kidney360*. 2025;6(5):720-7. doi: 10.34067/KID.00000000707.
9. Santos-Alonso C, et al. Pruritis in dialysis patients. Review and new perspectives. *Nefrologia*. 2022; 42 (1):15-21. DOI: 10.1016/j.nefro.2022.04.004
10. Fishbane S, et al. Pruritis severity and serum phosphate in CKD: A post hoc analysis of difelikefalin studies. *Kidney 360*. 2024; 5: 1270-1280. DOI: 10.34067/KID.0000000000000520

11. Davison S. Clinical pharmacology in pain management in patients with advanced kidney failure. *CJASN*. 2019; 14:917-931. DOI: 10.2215/CJN.05180418
12. Murtagh F, Sheerin N, Addington-Hall J, Higginson I. Trajectories of illness in stage 5 chronic kidney disease: a longitudinal study of patient symptoms and concerns in the last year of life. *Clin J Am Soc Nephrol*. 2011; 6(7): 1580-90. DOI: 10.2215/CJN.09021010.