Is there an age limit for starting haemodialysis?☆

¿Existe un límite de edad para iniciar hemodiálisis?

Dear Editor,

We present the case of a man with chronic kidney disease (CKD) on haemodialysis (HD) for 11 years, having started dialysis treatment at 86 years of age. His kidney disease started in 2005 with nephrotic syndrome which was not biopsied. He was followed in the low renal function outpatient clinic for approximately three years. He had been a widower for the past six years. Given his desire to receive dialysis treatment and the fact that his only child and carer was living in Las Palmas de Gran Canaria, he moved to the island of Gran Canaria. He received HD through a central venous catheter for three months, then through a native arteriovenous fistula.

His prior history of note included multifactorial chronic anaemia, chronic obstructive pulmonary disease (COPD) (pulmonary emphysema), atrial fibrillation with a controlled ventricular response, severe bilateral hearing loss and benign prostatic hyperplasia. He had no known ischaemic cardiomyopathy or cerebrovascular disease.

In November 2012, he was admitted with gallstones in the common bile duct with a need for endoscopic retrograde cholangiopancreatography (ERCP), sphincterotomy and gallstone removal. He subsequently presented no further similar episodes.

He visited the emergency department at our reference hospital on only one occasion with acute bronchitis and left ventricular failure, which markedly improved following medical treatment.

During his follow-up, his excellent adherence to dialysis treatment and complete independence for activities of daily living were always striking; he even went on holiday for up to two months in his city of origin, León.

In March 2019, he came into the emergency department with abdominal pain, vomiting and development of anaemia. He was diagnosed with primary bladder neoplasm in addition to a perivesicular collection suggestive of an abscess. It was decided that the patient would undergo conservative medical treatment and be admitted to the palliative care unit.

Up to a week before his death, at the age of 97, he remained on HD treatment; thus, the decision of the patient and his family was respected as his dialysis treatment was continued, provided, of course, that his haemodynamic situation allowed it.

Presently, with increasing frequency, clinicians taking care of elderly patients, must decide between starting renal replacement therapy (RRT) or a conservative kidney treatment. Hence, it is necessary to weigh up the risks and benefits of both options.[1]

As reported in the literature, although overall survival is usually higher in patients on dialysis versus patients not on dialysis, this advantage is lost in patients over 80 years of age, who present greater comorbidity, especially if they also have ischaemic cardiomyopathy.[2,3]

Another factor to be considered is the high burden of symptoms (pain, fatigue, anorexia, dyspnoea) presented by older patients on dialysis.[4] In addition, health-related quality of life is often deficient[5,6] and many present gradual secondary functional decline.

Given all the above, there is a growing interest in taking a more conservative approach to treat in elderly patients with advanced CKD.

However, with this case, we would like to spark reflection on the need to personalise RRT without considering only age as a limitation to starting dialysis, especially in elderly patients with limited associated comorbidity.

Our patient, already an octogenarian from the start, had a very high quality of life for 11 years thanks to an HD treatment that was started taking into consideration his limited personal medical history, given his low risk of mortality on the technique, and — no less importantly — respecting his treatment preferences after providing him with suitable information on all available treatment options.

Spain is a democratic country subject to Law 41/2002 of 14 November, regulating basic patient autonomy and rights and responsibilities with regard to clinical information and documentation (Boletín Oficial del Estado [Spanish Official State Gazette (BOE)] no. 274, of 15 November 2002; reference: BOE-A-2002-22188).[7]

Under this law, the patient has the right to freely choose among available treatment options after receiving suitable information. This heightens and enshrines patient autonomy regardless of age.

Thus, all healthcare professionals are obliged not only to properly exercise their professions from a technical point of view but also to fulfil their responsibilities in terms of clinical information and documentation and to respect the decisions made freely and voluntarily by their patients even in anticipated manner.

In summary, with this case, we hope to draw the attention of healthcare workers and authorities to the particular needs of elderly people with respect to nephrology medical care and encourage them to consider their

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patients' preferences and the right to receive all information required.

Even though most people over 80 may not benefit from starting dialysis treatment, the decision to start or not start dialysis treatment should be personalised, as it was the case of our patient. The right of each and every individual, regardless of age, to choose their own present and their own future should be respected and valued.

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Development of C3 glomerulopathy in a patient with acquired partial lipodystrophy☆

Desarrollo de glomerulopatía C3 en paciente con lipodistrofia parcial adquirida

Dear Editor,

Dysregulation of the activation of the alternative pathway of the complement is involved in the development of C3 glomerulopathy (C3G), a high percentage of cases are positive for the C3 nephritic factor autoantibody (anti-C3Nef),[1] the cause of the complement abnormality. This antibody may be associated with adipose tissue abnormalities, causing acquired partial lipodystrophy (APL),[2] which may appear before or after the onset of C3G.

We present the case of a 52-year-old man with a medical history of hypertension and APL of recent onset, being treated with enalapril 5 mg/24 h. He was referred to a nephrology clinic due to detection of albuminuria with levels that had been rising for years. The patient was asymptomatic. Physical examination revealed a lack of adipose tissue on the cheekbones, neck, upper limbs and trunk; normal blood pressure; and no oedema in the lower limbs. Given the differential diagnosis of APL, we ruled out causes associated with panniculitis, autoimmune diseases such as Barraquer-Simons syndrome, acquired generalised lipodystrophy (Lawrence syndrome), membranous and membranoproliferative glomerulonephritis (GN) (following kidney biopsy), drugs (cortisol, insulin), and viral infections such as HIV infection. Complementary tests showed that the patient had normal kidney function with creatinine 0.89 mg/dl, urea 38 mg/dl, sodium 139 mEq/l,

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