

Introduction

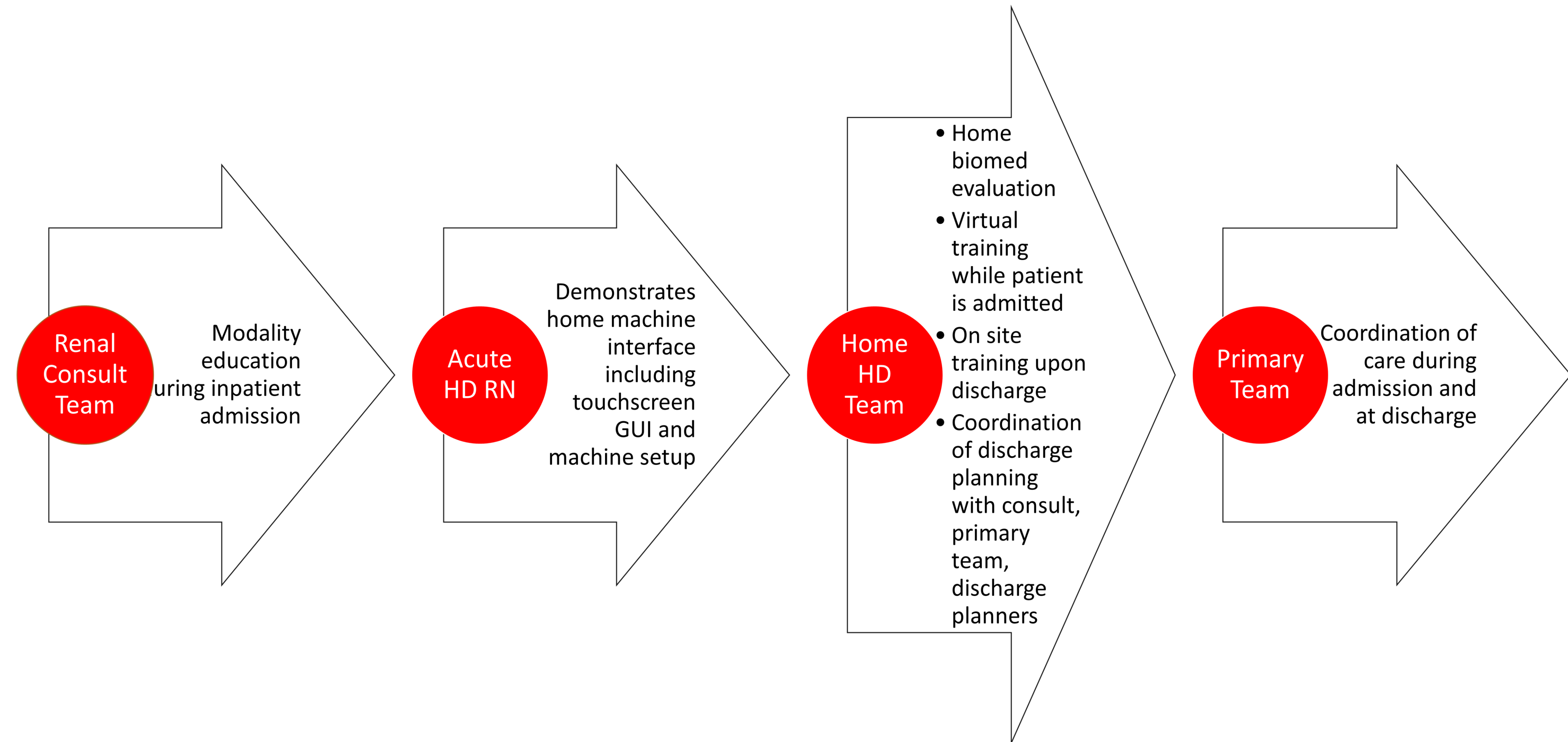
The transition from peritoneal dialysis (PD) to home hemodialysis (HHD) is rare, estimated at just 2.9%. Most of the transitions report interim and back-up in center HD during transition periods varying from 90 to 365 days¹.

Case Summary

A 52 year old male with ESRD due to diabetic nephropathy on PD, peripheral vascular disease requiring bilateral below-the-knee amputations (BKA) presented with abdominal pain and cloudy PD effluent. He was diagnosed with fungal peritonitis. Micafungin was initiated, the PD catheter removed, hemodialysis access placed.

During the hospitalization, the renal consult team discussed hemodialysis with the patient, including both home and incenter HD. The patient expressed his preference for continuing to treat at home, where he would have the ability to continue self-care and full-time employment despite his limited mobility due to bilateral BKA. The consult team then reached out to the HHD program with the goal of directly discharging the patient into HHD training.

In order to accomplish this, multiple services were engaged simultaneously. Within just a few days, the acute inpatient HD nurse was able to both treat with and introduce the patient to the Outset Tablo machine, including its touchscreen interface and explanatory on-screen animations. In addition, biomedical staff from the outpatient HHD facility were able to set up a home visit



to confirm suitability for HHD. The patient's wife was also able to visit the outpatient HHD training program for a hands-on informational session while the patient himself attended virtually.

Discussion

The patient was discharged from the hospital directly to HHD training. He completed training in six weeks and has since been successfully performing home HD with just minimal assistance from his wife. He has returned to work full-time and expresses confidence in his choice and satisfaction with his quality of life with HHD.

Conclusion

A successful urgent HHD start from a PD complication can be accomplished, but requires seamless collaboration between inpatient and outpatient teams, including the primary medical team, nephrology consult service, acute dialysis service, and outpatient HHD program. Of utmost importance is the care team initiating an open-ended discussion with the patient regarding potential modalities without acceding to providers' assumptions about patient's preference and ability.

Elbokl, et al (2021). Home-to-home dialysis transition. *Peritoneal Dialysis International*, 42(3)