Primary Hyperoxaluria Type 1: Treatment

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Introduction

High fluid intake and crystallization inhibitors are used as supportive treatments for Primary Hyperoxaluria Type 1 (PH1). A minority of individuals with certain PH1 genotypes (c.508G>A and c.454T>A) will react to pyridoxine, with a decrease in urinary oxalate excretion of more than 30%. The response of pyridoxine varies, and urinary oxalate may normalize in some individuals. The first targeted therapy for PH1 was authorized in 2020, utilizing an RNA interference agent to lower urinary oxalate, and such medicines may drastically modify treatment methods and long-term results in PH1. Currently, PH1 commonly causes renal function decline and frequently leads to End-Stage Kidney Disease (ESKD). With renal failure, urinary oxalate clearance declines, and multisystem oxalate deposition (oxalosis) ensues, most often in the bones, eyes, heart, and skin. Furthermore, the therapies used by social workers in response to psychological concerns in various stages of renal failure, as well as their effects on patients and families, are little unknown. Given the importance of psychological support for individuals diagnosed with kidney failure for both patients and health care providers, as well as the scarcity of data on social worker treatments for patients with kidney failure, the goals of this retrospective audit are to identify and compare The psychological concerns impacting patients during the pre-KRT or start of KRT and KSPC stages of the kidney failure disease trajectory, as well as the social worker treatments required in these two phases, are discussed, as are the social worker interventions advised at Phases 1 and 2 of illness.

We did a secondary data audit of patients who had psychosocial evaluations and were on KRT (Phase 1) or KSPC (Phase 2) between March 2012 and March 2020 in an Australian environment. Seventy-nine people, aged 70 to 12, had at least two psychosocial examinations, one in each of the two stages of the disease. The median period between Phase 1 and Phase 2 social worker assessments was 522 (116943) days. The most common psychosocial concern detected in Phase 1 was an adjustment to sickness and treatment (90%), which decreased to 39% in Phase 2. The need for elderly care services grew dramatically between Phases 1 and 2. In Phase 2, the social worker's psychosocial interventions increased significantly, including supportive counseling, education and information, and referrals.

We discovered that patients had distinct requirements that require different social work treatments in this multicentre research analyzing the variations in psychosocial needs of patients with kidney failure in the pre- or start of KRT and KSPC stages of disease that require social worker intervention.

Patients in the KSPC phase are more likely to require caregiver support, assistance from aged care agencies, and medical referrals, in addition to regular counseling and education on KRT. The findings of this retrospective audit demonstrate and confirm that participants in Phase 1 suffered widespread psychological distress in numerous parts of their daily lives as a result of renal failure and the start of KRT. When patients are in the supportive and palliative phases of their illness, their requirements alter, but their enormous emotional load and adaptive demands remain. The findings highlight the importance of social work intervention in easing psychosocial concerns and reducing internal and external barriers to maintaining physical, social, and emotional well-being. The interdependence of kidney failure's physical, psychological, and social effects on QoL emphasizes the necessity for a comprehensive and integrated strategy to delivering renal support services.

The study's findings must be viewed in light of the study's methodological shortcomings. The very small sample size from a specific situation may restrict the study's generalizability to other contexts. Furthermore, because the study was conducted retrospectively, it was not able to investigate the influence of the identified psychosocial factors or the participation of social workers on other patient-reported and clinical outcomes. Furthermore, due to the tiny and secondary nature of the data, any additional study to determine the influence of social worker treatments on a variety of psychosocial presentations was not possible. Finally, it is crucial to highlight that fewer than half of the participants in this study were born in Australia, and it is probable that cultural characteristics among the immigrant community impacted the results.

We discovered that people nearing or starting KRT have widespread psychological distress in numerous parts of their daily lives as a result of kidney failure, and that nephrology social workers can help. As patients advance to KSPC consultation, the enormous emotional load and adaptive expectations imposed on them shift visibly. Social work psychosocial intervention may be useful in treating some psychosocial difficulties and reducing internal and external barriers to maintaining physical, social, and emotional well-being. However, our understanding of the emotional impact before patients begin KRT, as well as throughout the supportive and palliative care stages, is still limited. More study is also needed to determine the impact of social work treatments on patient-reported outcomes.

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