

# Different Types of Dementia's Behavioral and Psychological Symptoms

Gaurav Singh Danggi\*

Department of Biotechnology, Graphic Era Deemed University, India

## Corresponding Author\*

Gaurav Singh Danggi

Department of Biotechnology, Graphic Era Deemed University,

India

E-mail:dangigaurav2808@gmail.com

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**Received:** 24-May-2022, Manuscript No. jok-22- 17945 (M); **Editor assigned:** 26-May-2022, Pre QC No. jok-22- 17945 (P); **Reviewed:** 02-June-2022, QC No. jok-22- 17945 (Q); **Revised:** 06-June-2022, Manuscript No. jok-22- 17945 (R); **Published:** 15-June-2022; DOI: 10.35248/2472-1220.22.8.4.25.

## Introduction

The number of individuals with renal failure receiving replacement treatment has grown considerably during the last decade. As the pros and cons of various dialysis modalities continue to be contested, clinical guidelines have accepted the concept of individualization of dialysis, which is assisted by collaborative decision-making among physicians, patients, and caregivers. However, there is still a significant vacuum in our understanding of how patients pick their dialysis modality.

Fotheringham et al. describe the findings of a discrete choice experiment among prevalent dialysis patients in this issue. The researchers looked at whether patients preferred extended session lengths (within a 3-times-a-week dialysis schedule vs 4-times-a-week Hemodialysis (HD or staying on the regular thrice-weekly dialysis regimen [1]. Among 183 dialysis patients, 38.3% elected to continue on their current dialysis schedule. When provided appropriate knowledge, however, 27.1% would prefer lengthier dialysis sessions and 34.3% would prefer 4 hours 4 times per week. Better quality of life, longer longevity, and less fluid restriction were factors that favored more intense dialysis, but increasing vascular access problems decreased the chance of selecting a regimen. Hospitalization had no effect on regimen selection. Patients under the age of 50 favored more rigorous regimens, placing a premium on survival advantage and fewer hydration restrictions [2].

This study focuses on the understudied topic of factors of patients' choice of dialysis modality. Notably, the research cohort comprised current dialysis users with an average dialysis vintage of 4.7 years, whereas earlier studies in the sector mostly involved patients with Chronic Kidney Disease (CKD) who were not getting kidney replacement therapy. The patients' previous experience with 3-times-a-week HD will undoubtedly influence their decision on dialysis dose. Another bias may arise from an unduly optimistic appraisal of survival, which may induce patients to place greater emphasis on this outcome than is expected.

While kidney transplantation is the gold standard of kidney replacement therapy, in-center HD is the most commonly used. In 2016, more than 80% of all maintenance dialysis patients worldwide got in-center HD. Hong Kong, the Netherlands, and New Zealand were exceptions, with fewer than 30% of renal failure patients undergoing in-center HD. Furthermore, in-center HD prescriptions varied by country, with Australia/New Zealand, Canada, Germany, and Sweden more likely to deliver thrice-weekly HD sessions of at least 4 hours than other nations. On the other hand, dialysis session lengths in the United States were the shortest [3]. Disparities in worldwide dialysis practice and patterns are determined by local resources, reimbursement regulations, infrastructure, and, most importantly, the knowledge and awareness of patients and nephrologists.

Even in resource-rich nations, dialysis prescription patterns deviate dramatically from those theoretically predicted by the current discrete choice experiment, in which a considerable number of surveyed patients chose extensive dialysis therapy. Similarly, other studies have found that when patients are given the right amount of information, they appreciate the benefits of more intensive or home-based therapy. Walker et colleagues found that when longer longevity and higher well-being were anticipated, CKD patients preferred home-based dialysis over in-center dialysis in another discrete choice experiment. Another research, by Morton et al, showed dialysis preferences of CKD patients and their families: Home dialysis was favored by 65% and 72% of people, respectively, over conservative therapy, especially as life expectancy is expected to rise [4].

How can one reconcile the disparities between the anticipated percentage of patients willing to adopt a more intensive type of home-based dialysis and reality? Discrete choice experiments are a popular statistical method for assessing individual characteristics, preferences, and priorities. Discrete choice tests, on the other hand, simply provide a theoretical possibility, and the results may not necessarily convert into an actual patient decision. However, it is reassuring to know that sufficient awareness of alternative dialysis modalities may influence the proportion of patients who choose more personally suited choices other than traditional 3-times-a-week haemodialysis.

To that end, current recommendations continue to urge nephrologists and care providers to use collaborative decision-making to offer the best goal-directed dialysis for all patients. Tragically, all too frequently, patients are forced to take the road of least resistance, with only in-center HD as an option. Moving ahead, the current findings should serve as a reminder to all nephrology practitioners that timely, iterative, and successful communication with patients on the benefits and drawbacks of all kinds of kidney replacement therapy should be a basic component of nephrology practice.

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