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Abstracts

□ ASSOCIATION OF SCHEDULED VS EMERGENCY-ONLY DIALYSIS WITH HEALTH OUTCOMES AND COSTS IN UNDOCUMENTED IMMIGRANTS WITH END-STAGE RENAL DISEASE.

Nguyen OK, Vasquez MA, Charles LLCSW, et al.
JAMA Internal Medicine. 2019;179(2):175-183

Scheduled dialysis has been proven effective at prolonging life for patients with end stage renal disease (ESRD) and is thus considered standard of care. Most people living in the United States are able to receive scheduled dialysis through either Medicare or Medicaid coverage. However in 40 out of 50 states, uninsured individuals ineligible for federal assistance, often undocumented immigrants, are denied that right and receive emergency only dialysis. Previous studies have suggested that this "compassionate" dialysis results in higher stress levels for patients, worse quality of life, and increased medical costs. Currently, there is little data that comparatively evaluates the cost, health outcomes, and utilization for scheduled versus emergency only dialysis.

The objective of this study was to measure the efficacy of scheduled versus emergency only dialysis in undocumented immigrants who live in Dallas, Texas. Due to the passage of the Affordable Care Act and the ban on exclusions for preexisting conditions, uninsured individuals were given an opportunity to gain access to private health insurance and charitable premium assistance, which ultimately led to them securing scheduled dialysis. Researchers conducted a retrospective observational study of uninsured individuals with ESRD who were 18 years old or older and were receiving emergency only dialysis in February 2015 at Parkland Hospital. Baseline data was gathered from 6 months prior to enrollment and patients were followed until 1 year after enrollment. Primary outcomes included death and healthcare utilization. Secondary outcomes focused on cost.

Of the 181 individuals enrolled, 105 were approved and enrolled in scheduled dialysis and 76 were denied placement in a dialysis center and remained on emergency only dialysis. These individuals were denied, not due to their comorbidities or documentation issues, but for issues related to the dialysis center such as lack of availability. At baseline, the patients who were enrolled for scheduled dialysis were younger, had more frequent presentations to the emergency department, and were on dialysis for a longer period of time. At 12 months they found that the mortality rates were lower in the scheduled dialysis group with an absolute risk reduction of 14% and a number needed to treat (NNT) of 7 (HR: 4.6 (95% CI: 1.2-18.2). Rates of health care utilization, defined as the number of emergency room visits, hospitalizations, and hospital days, decreased significantly in the scheduled dialysis group. Those having scheduled dialysis had 5.2 fewer ED visits per month, for example (Difference-in-Difference: −6.2 ED visits per month, 95% CI(−7.0 to −5.4)). With respect to cost, baseline price per person per month (PPPM) decreased significantly a year after enrollment, showing a net decrease of $4316 PPPM for patients who were enrolled in scheduled dialysis (Difference-in-Difference: −$5768, 95% CI(−8332 to −3204)).

The authors conclude that scheduled dialysis is superior to emergent dialysis and leads to lower mortality, cost, and healthcare utilization. The authors recommend that scheduled dialysis should be the standard of care for **all** persons with ESRD in the United States.

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Comment: Emergency departments and hospitals across the country feel the burden of emergency only dialysis and would benefit from a safe and cost-effective solution. This is the first evaluation of scheduling dialysis in patients who previously were only able to obtain emergent dialysis. While this is retrospective and some of the outcomes may not be generalizable across the country, this important study indicates that scheduled dialysis is preferred to save lives and money.

□ EARLY USE OF NOREPINEPHRINE IN SEPTIC SHOCK RESUSCITATION (CENSER): A RANDOMIZED TRIAL.

Permpikul C, Tongyoo S, Viarasilpa T, et al. *Am J Respir Crit Car Med*. 2019, Feb 1. doi: 10.1164/rccm.201806-1034OC

Recent retrospective analyses have indicated a possible utility in early administration of norepinephrine (NE). Permipikul and colleagues designed single center, double blinded RCT to evaluate these claims prospectively.

The goal of the study was to evaluate the utility of early low-dose NE in septic shock. Patients were eligible if they were aged > 18 years and presented with MAP < 65mmHg and suspected sepsis. They were randomized to receive early low dose NE through a peripheral IV at a rate of 0.05μg/kg/hr in addition to standard of care (fluids, antibiotics, and open label