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FROM THE
QIRN3 PATIENT ADVISORY
COMMITTEE

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FLUID RESTRICTION: YOUR BIGGEST CHALLENGE

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The average dialysis patient has limited urine output. It is probable that people on dialysis will eventually stop making any significant amount of urine. With fluid, you should not put it in if you cannot put it out. This results in the need for a daily fluid restriction.

As an experienced renal dietitian, I have heard new patients say "I'd rather drink than eat". "They told me to eat ice instead of drinking". It has become evident that ice is addictive and what is heard and implemented can be the result of selective hearing. It is human nature to want what you cannot have. If you can commit to *moderation*, you can have anything.

1000cc is one liter which is comparable to a quart. A liter weighs 2 pounds and a kilogram is 2.2 pounds. The amount of weight that you are over your dry weight will be used to set the amount of fluid removed during your treatment that day. The intradialytic weight gains (IDWG) progressively improve through the week. Then comes the three day weekend. Weekends can be exceptionally challenging to control fluid intake. Overhydration can cause a difficult treatment. Symptoms can include: elevated blood pressure, shortness of breath (SOB) and dry mouth. Your treatment can end with cramping and low blood pressure that may require giving saline solution: more fluid. And the cycle goes on. If one could start off better on a Monday/Tuesday by decreasing the fluid weight gain on the weekend, one can improve comfort levels and overall sense of well being.

For the extended interval, the 'weekend campaign' can be implemented. That is: NO SOUP, NO SODA, NO ICE. Many will respond, "I don't eat soup, and I don't drink

soda." Ice is often identified as the downfall. *Ice pica* can take hold. Ice can be very soothing to dry mouth, known as xerostomia, but only while it is in your mouth. Refills are consumed and not measured. Ice has no nutritional value like nutrition supplements provide. Supplements are 'worth' the fluid load.

Why is it that the more you drink the thirstier you feel? In review of chemistries, it has been noted that sodium levels can be below normal ranges. This is referred to as hyponatremia. In fluid overload, sodium is diluted. It's as if you added 10 ounces of water to an instant cup of soup that called for only 6 ounces. Dilution can suppress the salivary gland, located under the tongue, reducing the secretion of saliva. The mouth, tongue, and even the teeth become dry. This can result in increased risk of dental problems.

Some people experience xerostomia as a complication of medications but it is not often associated with fluid overload, and always interpreted as *thirst*. Since drinking more is not helping the situation, one should practice alternative techniques to *sooth the oral cavity*. Try the lozions and gums available that are designed by dentists. Rinse your mouth, without swallowing. Chill a mild mouth wash and rinse with that when episodes of dry mouth 'drive you to drink'. Drink your fluids with meals and medications only. Develop the pattern of avoiding fluids in between meals. Try adding a slice of fresh lemon to your beverage. Just thinking about lemons tends to stimulate the salivary gland.

Consider a measured portion of watermelon as your 'beverage'. If soup is consumed, try eating with a fork or

slotted spoon. Restricting sodium intake and controlling blood sugars results in more acceptable fluid weight gains also. Your Registered Dietitian is there to help and provide support as you face all the challenges of your renal diet.

Skin Cancer- What Should I Know?

Why should I be worried about skin cancer? You may be thinking that as you scan this article. Skin cancer is the leading form of cancer in human beings. Each year, greater numbers of patients are diagnosed with skin cancer. There are three main forms of skin cancer; basal cell carcinoma, squamous cell carcinoma and melanoma. If not diagnosed and treated early, some skin cancers can grow and become disfiguring while others, most likely melanoma, can metastasize and result in death.

Who is at risk for skin cancer? Skin cancer is seen in many parts of the world. It is most common in the sunny climates such as Australia and South Africa and throughout the US. Skin cancer rates are highest in Caucasian individuals. Excessive exposure to sunlight is the main cause of skin cancer. Sunlight contains ultraviolet (UV) rays that can alter the genetic material in skin cells, causing mutations. Sunlamps, tanning booths, and X-rays also generate UV rays that can damage skin and cause malignant cell mutations. It has also been estimated that nearly half of all Americans who live to age 65 will develop skin cancer at least once.

What does skin cancer look like? A basal cell carcinoma usually begins as a small, dome-shaped bump and is often covered by small, superficial blood vessels called telangiectases. The texture of such a spot is often shiny and translucent, sometimes referred to as "pearly." It is often hard to tell a basal cell carcinoma from a benign growth like a flesh-colored mole without performing a biopsy.

Squamous cell carcinoma of the skin occurs roughly one-quarter as often as basal cell carcinoma. Light-colored skin and a history of sun exposure are even more impor-

tant in predisposing to this kind of cancer than to basal cell carcinoma. Men are affected more often than women. The earliest form of squamous cell carcinoma is called actinic (or solar) keratosis. Actinic keratoses appear as rough, red bumps on the scalp, face, ears, and backs of the hands. As with basal cell carcinoma, doctors usually perform a biopsy to make a proper diagnosis.

Nonmelanoma skin cancer is generally curable. The cure rate for nonmelanoma skin cancer could be 100% if these lesions were brought to a doctor's attention before they had a chance to spread. Treatment of nonmelanoma skin cancer depends on the type and location of the skin cancer, the risk of scarring, as well as the age and health of the patient.

Are there increased risk factors of skin cancer for ESRD patients? One form of skin cancer known as Merkel Cell Carcinoma is seen in kidney transplant patients. MCC is associated with a profoundly weakened immune system, such as in patients who have received an organ transplant and who are on medications that suppress the immune system. The risk of developing MCC is increased 10-fold in organ transplant patients according to one study. While patients with profound immune suppression are at a higher risk of developing MCC, over 90% of all people who develop MCC in fact have a normal immune system.

How should I monitor myself for skin cancer? Avoiding sun exposure in susceptible individuals is the best way to lower the risk for all types of skin cancer. Use sun screen with a high SPF number. Regular surveillance of susceptible individuals, both by self-examination and regular physical examination, is also a good idea for people at higher risk. People who have already had any form of skin cancer should have regular medical checkups.



Information for this article was obtained at:

www.medicinenet.com

Article by Alan Rockoff, MD and www.merkelcell.org

JOIN THE PAC TODAY!

The Patient Advisory Committee (PAC) for QIRN3 consists of dialysis patients and those who have transplanted. The committee meets quarterly to discuss issues relevant to ESRD patients. The PAC members have a genuine concern for quality of care issues and encourage patients to be involved in their healthcare. They are willing to share skills and experience with others. Call toll free 1-888-877-8400 to join the PAC.

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