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PATIENT TO PATIENT... A NEWSLETTER SERIES FOR THE AAKP PATIENT PLAN



THE AAKP PATIENT PLAN[®] PHASE 2: ACCESS AND INITIATION



A Friendly Note: Congratulations, I'm glad to see you've elected to receive Phase 2 of the AAKP Patient Plan[®].

I'm here to help guide you through this part of your journey with **end-stage renal disease (ESRD)**. I remember my first dialysis session. I had a lot of questions and concerns running through my head. Luckily, you can use the AAKP Patient Plan[®] as your road map. It provides you with the needed directions and highlights potential speed bumps. Its purpose is to steer you toward a healthy life with ESRD. Whether you've chosen **hemodialysis, peritoneal dialysis** or **transplantation**, the AAKP Patient Plan[®] provides the resources you're seeking during this stage of care. A few topics you can expect to learn more about include hemodialysis, peritoneal dialysis and transplantation; intimacy issues you and your partner may wish to discuss; rehabilitation resources and benefits; exercise hints and tips; your new medication regime; specific diets for all treatment choices; laboratory blood tests and the importance of these tests, to name just a few.

The program's main objective is to provide renal education, when it is required, as you experience the different phases of care. The different phases are as follows:

Phase 1: Diagnosis to Treatment Choice


Phase 2: Access and Initiation

Phase 3: Stabilization

Phase 4: Ongoing Treatment

The diagnosis of kidney failure has created changes in your life, and now that you've started your treatment option, this too will affect certain aspects of your lifestyle. With the assistance of your healthcare team and AAKP, you and your family members have the necessary tools to make an educated decision regarding your healthcare. As with Phase 1, I suggest you take your time when reviewing the information in this newsletter and the accompanying book. There are also some checklists to assist you with knowing when things occur within your journey. Use page 12 of this newsletter to write down any questions related to information found in this newsletter or the book. Take your list to a member of your healthcare team. Together, you and your healthcare team can work to ensure a good quality of life and quality of health. 🌐

JUDY'S DANCE THROUGH LIFE

 *A Friendly Note: I enjoyed reading about Judy's experiences with dialysis. I learned that other people have faced some of the same feelings I did. It made me feel normal as an ESRD patient.*

Once the music starts, you'll be lucky if you can keep up with her on the dance floor. Maybe it's her determination to have fun or three years of acting lessons that have strengthened her outgoing personality. Whatever it is, Judy Weintraub has set a goal to live a memorable life and that's exactly what she's doing.

More than 25 years ago, Judy was diagnosed with ESRD. At 15, she and her family were not sure what that meant. Together, along with support from healthcare professionals and other ESRD patients, they were able to put the pieces in order and begin to solve the puzzle. Today, Judy's triumphs and challenges can serve as an inspiration to other individuals facing the uncertainty of ESRD.

For the past 12 years, Judy has been on peritoneal dialysis. She performs four exchanges every day and has been known to do an exchange while driving home from work. She made the decision to purchase her Jeep Cherokee because there was a hook on the visor, which was high enough to hang her **dialysate** bag, allowing gravity to perform the exchange. For some, this may sound strange, however it's typical for Judy, she adapts situations to her dialysis and does not allow the dialysis to adapt her. This was not the case for Judy years ago.



Judy's first choice of treatment was hemodialysis. She had her first session when she was 15. "The young scared girl I was at the beginning of dialysis looked outside of me for clues as to how to live my life. I covered my **fistula** with long sleeves because I couldn't bear the constant reminder," said Judy. "It took a long time to learn to look inside for the answers. It's up to each of us to discover who we are and what our paths are."

Several years ago, Judy traveled to Israel with her sister, brother-in-law, neice and nephew. This was a big challenge, as she had never traveled outside of the U.S. because of concerns about adequate medical care. However, an opportunity presented itself and Judy could not let it slip away. She planned every detail of her trip from the delivery of the dialysate to securing names and phone numbers of two nephrologists in Israel in case of an emergency. She also devised a plan, including sterilization techniques, to perform two necessary exchanges in the airplane lavatory during her travels. The one thing she did not anticipate was reaching a new level of acceptance regarding her illness.

Judy admits she had some difficulty with revealing aspects of her illness and dialysis to her family and friends. She wanted people to know her for her, and not for the fact that her kidneys didn't work. She went to school, began a career, and kept the two areas of her life separate. When her sister started a family, she developed a close relationship with her niece and nephew and discovered she was falling back on old habits with her perception of her illness.

CONTINUED ON PAGE 8



DISCUSSING WHAT'S BEHIND BEDROOM DOORS

A wife discusses her experience with her husband's impotence.

If I've learned one thing with kidney failure, it's that ESRD affects the whole family. There are many challenges we all must overcome. There are changes in our lifestyles, such as adjusting our diets (i.e. not cooking with salt) and altering vacations, to fit a dialysis schedule. However, all these modifications, whether small or large, are worth it for the successful health of your loved one. The one key issue to remember is to keep a line of communication open and work through whatever challenges you face.

My husband had been on hemodialysis for several months. He seemed to be adjusting well to the treatments both physically and emotionally. We were concentrating on his health, diet and laboratory results, but we were also moving on with our lives. It was important to both of us that we allowed ESRD to become a part of our lifestyle, but not so much that it became our life.

I was pleasantly surprised, because I thought it would have taken much longer for my husband to accept the changes related to kidney failure and beginning hemodialysis. He was feeling better and had adjusted to the three times a week dialysis schedule. Because he was physically feeling better, we felt it was all right to begin sexual intercourse again. His nephrologist told us it was fine to have sex, but he did warn us that **erectile dysfunction (impotence)** can be common with dialysis and transplant patients. But my husband was feeling so much better that we honestly thought it wouldn't happen to him.

After being on hemodialysis for about six months, my husband could no longer produce an erect penis. Even though we were warned of this potential problem, we didn't expect it to happen, and we certainly didn't prepare for it. I kept wondering if I should even care about this. My husband was doing well on dialysis, he was healthy and he was adjusting. Did it really matter if we couldn't have sex? Was I being selfish and only concerned about my needs? After all, there are more important things than sex, and my husband's overall health was one of them.

What I failed to realize is that sex is also a part of my husband's overall health. I was willing to drop the subject because I didn't feel comfortable talking to anyone about it. Fortunately, my husband didn't feel the same way. First, we tried to work it out ourselves. Sometimes we would have success and other times we wouldn't. It was my husband's suggestion that we talk to his nephrologist.

I was embarrassed at first. I had always thought sex was one of those topics you kept behind bedroom doors. However, my husband's doctor was open about the subject and concerned about what we were experiencing. I quickly overcame my fear of discussing this topic with others. The doctor first examined things in our lives, which could be causing the erectile dysfunction. He asked if we were under any severe stress and if there was anything that we thought was causing the problem. After assessing that our lives were no more difficult than any other normal couple, he took a look at all of my husband's prescriptions to see if one of

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the drugs was the culprit. It turned out one of the side effects of his blood pressure medication was decreased sexual function. After a quick change in his prescription, my husband and I left the doctor's office with hope that this simple solution would solve our problem.

It has now been six months since we talked to my husband's doctor. Luckily, everything is going well, including our life behind the bedroom door. However, I learned it isn't always best to hide your fears because you don't think the subject is really that

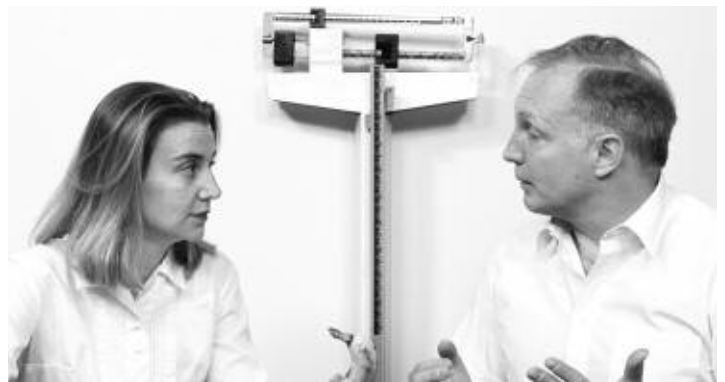
important. Everything that happens to someone who has ESRD also, in one way or another, affects his or her family. You can't solve anything if you don't work it out and if you're not willing to discuss it with others.

We know that this could be a challenge we face again some time in the future. But, we also know there are numerous resources for us and it's OK to discuss this issue with members of my husband's healthcare team. After all, how will they know to help if you don't let them know something is wrong? 🌐

Me and My Social Worker: What Can I Expect?

Often times, the social worker is one of the first healthcare team members, after the physician, who you'll meet. There are basic services you should receive from your social worker. The most important, however, is that of helping you and those who love you regain control. The basic services are broken into several areas: psychosocial evaluation, service coordination, information and referral, counseling patients and families, treatment planning, advocacy, and patient and family education. Each area is meant to enhance the emotional and social quality of life throughout your journey with ESRD.

The psychosocial evaluation is one of the first points of contact. The social worker wants to hear your story of how you view your family, health, losses, finances, cultural beliefs and successes. This information helps the social worker understand how you perceive all that has happened and how you anticipate what is to happen to you. The social worker will use this information to make an initial and ongoing assessment of your emotional needs.



In the area of service coordination, you can expect the social worker to coordinate the various types of services you may receive or need to receive in order to eliminate duplication, increase efficiency and offer effective access to services in and out of the ESRD setting. In short, your social worker will work with you to help YOU access services to meet your changing care needs.

When it comes to information and referral, you should expect your social worker to have knowledge of, or access to, information or services for which you may be eligible. In some cases, you and your social worker will be learning about a resource together, so be patient, social workers are human, not directories. The social worker's knowledge of local, state and federal services will certainly cut your time in securing information or gaining access to services and programs available to you.

Your social worker is part of the treatment planning team. The social worker provides information about you and your family's emotional and social status, in order to develop and update or revise your individualized treatment care plan.

In the area of advocacy, you can expect your social worker to work with agencies to educate them on the needs and issues specific to ESRD patients and their families. The process will help you gain access to services and programs that may have been originally denied to you. In the role of patient advocate, the social worker is able to represent you where you may not have any such representation. This can take the form of letter writing to government officials on issues about legislation that can affect ESRD patients and their families.

The last two areas, patient and family education and counseling patients and families, are critical to the emotional health of you and your family. In order for you and your family to begin to understand and deal with ESRD, you need information. The social worker can provide you with user-friendly information so you can cope with all that is happening to you. Things like treatment choices, rehabilitation, Medicare, medication, resources and the like need to be introduced so you can benefit from the information in those areas.


The counseling of patients and families is an ongoing process. It may not always take place in an office for the so-called "50 minute hour," but it is critical to your emotional health. Your social worker is qualified to provide counseling in areas such as crisis intervention, behavioral therapies, individual, couples and family counseling, termination of treatment, alternative treatments, rehabilitation, advance directives, and psychological, social and financial stresses as a result of medical complications. The key is that a qualified social worker is available to you. She will help you attain the best outcomes possible for you, not only medically but emotionally and socially as well.

Find out who your social worker is if you do not know. Ask how you can partner with him or her to receive this important service, which is essential for your total health. 🌐

Written by Rosa Rivera-Mizzoni, MSW. Rosa is the special projects coordinator for The Renal Network, Inc. (ESRD Network 9 and 10). She is also a former member of the AAKP National Board of Directors and assisted with the development of AAKP Patient Plan®.

Caution: Heart At Work!

Tips on Potassium Control for Hemodialysis Patients

 *A Friendly Note: This article can give you some good information about potassium. Remember, consult with your dietitian before making any changes in your diet.*

Potassium is a vital mineral for regulating your heart. It comes from the foods we eat, as well as certain medications. A healthy kidney will regulate the amount of potassium in the bloodstream by excreting any extra potassium in the urine. When kidney function is reduced, potassium builds up in the blood to high levels.

A high potassium level is extremely dangerous. It can make your heart stop without warning. Some side


effects include weak muscles (especially leg), irregular heart beat, diarrhea and nausea/vomiting. For a healthy heart, your potassium level should range between 3.5-6.0 milliequivalents per liter (mEq/L).

Going to dialysis and staying for your full treatment is one of the ways to control your potassium. Diet is the other way to control your potassium.

1. Know your diet! To control your blood potassium, limit high potassium foods. If your serum potassium is consistently less than 5.5 mEq/L, you may have a scheduled "cheat time."



DISCUSSING IMPOTENCE WITH YOUR HEALTHCARE TEAM

 *A Friendly Note: For some of you, the subject of this article, and the suggestion to discuss it, may embarrass you. However, I know that it's really important to feel comfortable talking about impotence and any other topics with your partner and healthcare team. It's difficult to travel the road of ESRD if you don't communicate with this team.*

In all chronic illnesses, a loss of interest in sexual activity is common. Progressive kidney failure is no exception. Whether treated by peritoneal dialysis, hemodialysis or transplantation, all studies find sexual interest is diminished in ESRD patients. Such a reality should not be a surprise. Coping with the stress of an abdominal or vascular access for dialysis, surviving the usual muscle loss, and getting used to medications and other treatments pose adjustment stresses that place sex at a low priority. After serious illness, attempting to return to sexual function is easier for a woman than for a man who must be able to produce an erect penis. Lowered sexual interest affects both male and female ESRD patients. While this article focuses on impotence, females should also understand the importance of discussing this subject with members of their healthcare team.

To properly treat impotence, or penile erectile dysfunction, it's important to discuss sexual dysfunction with your healthcare team. Discussing your lowered sexual interests will assist your healthcare team in determining proper treatment.

The first step in evaluating a complaint of impotence is to identify and fix all correctable medical problems. Discovery of undiagnosed tuberculosis, diabetes, **anemia** and thyroid disorders are examples of diseases that reduce interest and perform-

ance in sex. For dialysis patients, proper nutrition (serum albumin of about 4.0 g/dl), ensuring adequate dialysis as measured by either **urea reduction ratio (URR)** or Kt/V, plus improvement in anemia to an approximate hematocrit of 35 percent are key measures permitting attention to sex.

The second step is to review all prescribed medications to check for any impact on sexual function: antihypertensive drugs (blood pressure medications) and female sex hormones are the most usual offenders. By reviewing medication history, it may become apparent that the problem began shortly after starting drug "X." In such cases, the solution is easy: the doctor will change the prescription from "X" to "Y" with careful attention to whether the new drug works as well. Some antihypertensive drugs have been linked to impotence.

The third step is an in-depth look at all aspects of life quality. Are work hours exhausting? Is the home a place of conflict? Is the subject's mother dying of cancer? Is the spouse having an affair? Sometimes, just taking an inventory of what is happening will reveal a point that may be easily fixed. At this point, intervention by a social worker, psychologist/psychiatrist or motivated member of the renal team may be all that is needed.

The fourth step is a complete urologic evaluation. Is the equipment needed for sex in working order? By excluding defects in the anatomy of the bladder, prostate gland, urethra (tube from the bladder to the outside) and testicles, the urologist determines what treatment is an option.

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Over the years, there have been several medical treatments for impotence. As the treatments evolved to become less stressful on the body and more effective, corrective therapy such as Viagra® appeared on the medical and social scene. In a dose of 25-50 mg taken about 30 minutes before attempting sex, Viagra® strengthened and prolonged erections permitting a restoration of sexual relations in as many as three-quarters of subjects in clinical trials. Patients on dialysis or with a functioning kidney transplant were not included in these studies. Subsequently, small series of ESRD patients given Viagra® have been reported with surprisingly positive outcomes from more than half the subjects and their partners. No unanticipated adverse effects were noted. Both diabetic and non-diabetic men gave positive accounts on how Viagra® transformed their lives.

Worry about heart attacks is the main concern when prescribing Viagra®. Men, who have angina under treatment with nitroglycerine or similar drugs, may be at extra risk of sudden death from a heart attack when treated with Viagra®. This risk has not been confirmed and should now be classified as a worry rather than a reality.

Should you take Viagra®? Considering the very small number of deaths in men given Viagra®, any risk appears small compared with the probability of benefit. Most importantly, tell your nephrologist that you have a problem with impotency and want to work together to find the best solution. 🌐

Written by Eli A. Friedman, MD. Dr. Friedman is chief of the division of renal disease for State University of New York, Health Science Center at Brooklyn. He is also chairperson of the AAKP Medical Advisory Board.

You can have one high-potassium food item on the evening before or for breakfast on the day of your scheduled dialysis treatment. If you dialyze in the evening, the cheat time should be either for breakfast or lunch on dialysis day.

2. If your potassium is consistently less than 4.5 mEq/L, you may have one high potassium food item each day eaten in specified portion sizes. A typical portion size is 1/2 cup. You need to know the number of servings allowed in your meal plan since all foods contribute some potassium. Consult your renal dietitian on portion sizes and allowed servings.

3. Take advantage of fruits and vegetables in season when they are at their best. Use these for the scheduled cheat time.

4. Some high-potassium food items, such as a slice of tomato on a sandwich or a tomato wedge on a salad, can be eaten in moderation.

5. Certain vegetables, such as potatoes, carrots, beets, broccoli, squash and cauliflower can be soaked or “dialyzed” to remove some of the potassium. If the process is done properly, approximately one-third to one-half of the potassium may be leached from potatoes.

6. Substitute turnips for potatoes in recipes.

7. Use canned fruits instead of fresh fruits because the canning process removes some of the potassium. Try a fruit cocktail for dessert.

8. Call AAKP to receive the *AAKP Nutrition Counter: A Reference for the Kidney Patient*, which gives you potassium levels for many of your favorite foods.

“Dialyzing” vegetables reduces the potassium content. The following method can be used:

1. Peel the vegetable and cut into small pieces.
2. Soak in large amount of water for four hours or overnight (for one cup of vegetables use five cups of water).
3. Drain the water and rinse the vegetables.
4. Cook in a large pot of water until tender.
5. Drain the water and prepare as desired. 🌐

Written by Maria Karalis, MBA, RD, LD. Maria is a nutrition consultant for ikidney.com.

“For years I had tried to make situations easier for myself and others by hiding my dialysis behind closed doors. Though I loved peritoneal dialysis for the freedom and control it afforded me, I had difficulty openly doing exchanges in front of others. Part of me still wanted to pretend it didn’t exist,” said Judy.

Eventually, Judy realized how much unnecessary stress she was placing on herself by trying to hide her need for dialysis. It was during her trip to Israel, on a dusty road during her first day of touring, that she announced she would be doing two dialysis treatments each day while riding in the van.

“I pulled out my solution bag, described to the tour guide how the procedure worked, hung the bag on the sun visor latch and distributed masks to everyone for my hook-up. A few curious questions were asked and then the tour guide resumed his historical narrative. I never felt freer,” said Judy.

Even before Judy’s trip to Israel with her new found acceptance, she overcame many hurdles related to her kidney failure. She started hemodialysis in 1975 during a time when the dialysis process was much less refined than it is today. Three months after starting hemodialysis she received a kidney transplant. The transplant only lasted four months and Judy was placed back on hemodialysis. She continued on this form of treatment for 12 and a half years until she switched to peritoneal dialysis. During her entire time on peritoneal dialysis, she hasn’t had one occurrence of **peritonitis**.

As a long-term patient, Judy has witnessed many changes in both herself and the treatment process for ESRD. She has experienced all three modalities and admits she is partial to peritoneal dialysis. It gives her additional control over her healthcare and provides her with a sense of freedom that she says hemodialysis did not. However, everyone has his or her own preference. What works for one individual, may not be the solution for another.

“Through the years, I have learned that choosing a treatment option is a very individual decision. Every circumstance is different. It’s also important to remember that if something isn’t working for you, it is possible to switch from one option to another,” said Judy.

Judy remembered a time five years ago when she visited a doctor of physical medicine. She was experiencing pain in her joints, which can sometimes occur in long-term patients. She was upset and concerned about the impact this joint pain would play in the years to come. She remembers what the doctor told her and wishes someone had said it long before.


“The doctor told me, ‘live your life.’ I took this advice to heart and I still do today,” said Judy. “If you hang in there, follow your course of treatment, follow your diet, keep your eye on the long-term and ride out those difficult waves, it’ll get better. All said and done, I am so grateful dialysis exists. I have lived the past quarter of the 20th century because of the gift of my lifetime – dialysis. Without it, I wouldn’t be here.” 🌍

Visit
AAKP'S
Web site at
www.aakp.org



WHERE SHOULD I CALL?

Resources for you in your search for knowledge

 *A Friendly Note: Here are some very useful phone numbers. For me, it was helpful to contact organizations when I had questions about things that were happening to me.*



Diabetes

American Diabetes Association

800-342-2383 / www.diabetes.org

Provides printed materials and referral information related to diabetes.

Eyesight

Prevent Blindness America

800-331-2020 / www.preventblindness.org

Provides informational pamphlets and brochures about various conditions related to eyesight.

Kidney and Urologic Diseases

American Association of Kidney Patients

800-749-2257 / www.aakp.org

Serves the needs and interests of kidney patients and their families. Founded by kidney patients to help fellow patients cope with the physical and emotional impact of kidney disease.

American Kidney Fund

800-638-8299 / www.akfinc.org

Provides direct financial assistance, educational programs, research grants and community service projects for the benefit of kidney patients.

National Kidney Cancer Association

800-850-9132 / www.nkca.org

Source of information for material related to kidney cancer.

National Kidney Foundation

800-622-9010 / www.kidney.org

Seeks the answer to diseases of the kidney and urinary tract through prevention, treatment and cure.

Polycystic Kidney Research Foundation

800-753-2873 / www.pkdcure.org

Provides in-depth information about polycystic kidney disease.

Organ Transplantation

Transplant Recipients International Organization

800-874-6386 / www.trioweb.org

Provides a variety of educational services related to transplantation.

United Network for Organ Sharing

804-330-8500 / www.unos.org

Maintains the organ transplant waiting list.

Provides information about the transplant waiting list, financial aspects and transplant center ratings.

Rare Disorders

National Organization for Rare Diseases

800-999-6673 / www.rarediseases.org

Acts as a clearinghouse of information about rare disorders and provides a network for mutual support to match families with similar disorders. 🌐



AAKP EXISTS
*to serve the needs
 and interests of kidney
 patients and their
 families.*

MEMBERSHIP

MEMBERSHIP APPLICATION

I am not interested in membership at this time; however, I would like to receive a complimentary package of information.

To join AAKP, complete this form and send it with your payment to:
 AMERICAN ASSOCIATION OF KIDNEY PATIENTS
 3505 E. FRONTAGE RD., SUITE 315
 TAMPA, FLORIDA 33607-1796

Membership Information:

Name:

Address:

City: State:

Zip:

- Transplant Hemodialysis CAPD
 CCPD Family Member Pre-ESRD
 Other _____

I am already a member of AAKP, but I would like to make a donation of \$

Indicate your AAKP membership category below:

- Patient/Family Member (\$25)
 Professional Member (\$35)
 Sustaining Member (\$100)
 Institutional Member (\$150)
 Life Member (\$1,000)
 Check Enclosed (payable to AAKP)
 Please charge my credit card:
 Visa MasterCard AmEx Discover

Account Number

Expiration Date

Signature

Please cut along dotted line.

Founded in 1969, AAKP continues to be the only organization directed by kidney patients, for kidney patients. AAKP is devoted to the interests and concerns of people with kidney disease.

As a member, you will meet people with similar experiences. You will learn about kidney disease, how to control it and who to turn to for help. In other words, we are here to help you with the answers and guidance you need to live a full and productive life.

HOW YOU CAN JOIN AAKP

Patient/family membership in AAKP is \$25 annually. Professional membership is \$35 per year. Please call AAKP at (813) 636-8100 for international rates. To join, just fill out the membership application form and send it with your payment to AAKP. For immediate membership, call (800) 749-AAKP. Please have your credit card information ready.

HOW AAKP HELPS YOU

AAKP offers you the following benefits:

- Subscription to AAKP's magazines, *aakpRENALIFE* and *Kidney Beginnings: The Magazine*.
- An opportunity to subscribe to *AAKP Renal Flash*, *Kidney Beginnings: The Electronic Newsletter*, *Kidney Transplant Today* and *AAKP Public Policy Briefing*, Internet newsletters transmitted monthly.
- A Web site (www.aakp.org) displaying useful healthcare information and providing links to other renal-related sites.
- A membership packet filled with a wide range of informational brochures on issues affecting the care and treatment of kidney patients.
- An opportunity to attend our Annual Convention, a three-day event featuring seminars addressing treatment options, rehabilitation, and psychological and social concerns of renal disease patients.
- Local AAKP Chapters (where available) that provide social and educational support to you and your family with meetings, newsletters and group activities.
- Special interest brochures that address current medical issues.
- Assurance that AAKP is representing your interests by defending the Medicare ESRD Program.



GLOSSARY



Anemia

The condition of having too few red blood cells. If red blood cells are low, the body does not get enough oxygen. *See also Epogen®.*

Blood Urea Nitrogen (BUN)

A waste product in the blood that comes from the breakdown of food protein. The kidneys filter blood to remove urea. As kidney function decreases, the BUN level increases.

Continuous Ambulatory Peritoneal Dialysis (CAPD)

The most common type of peritoneal dialysis. With CAPD the blood is always being cleaned. The procedure uses a system of bags and tubing. No machine is required.

Continuous Cycling Peritoneal Dialysis (CCPD)

A form of peritoneal dialysis that uses a machine. The machine automatically performs the exchanges while the person sleeps and typically involves three to five exchanges. This is also sometimes called ambulatory peritoneal dialysis (APD).

Creatinine

A waste product from meat protein in the diet and from the muscles of the body. Creatinine is removed from the blood by the kidneys. As kidney disease progresses, the level of creatinine in the blood increases.

Dialysate

A specially formulated liquid solution used in peritoneal dialysis.

Dialyzer

A part of the hemodialysis machine that removes wastes and extra fluid from the blood.

End-Stage Renal Disease (ESRD)

Total chronic kidney failure. When the kidneys fail, the body retains fluid and harmful wastes build up. A person with ESRD needs treatment to replace the work of the failed kidneys.

Epogen® (Epoetin Alfa)

A medication that assists your body to produce red blood cells. The medication acts the same way as the natural human hormone **erythropoietin**. When someone experiences kidney failure, the body does not produce erythropoietin the same way it did when the kidneys functioned normally.

Erectile Dysfunction

See impotence.

Erythropoietin (EPO)

A hormone produced by the kidneys that stimulates the production of red blood cells.

Fistula (Arteriovenous Fistula)

Surgical connection of an artery directly to a vein, usually in the forearm, created in patients who will need hemodialysis.

Hemodialysis

The use of a machine to clean wastes from the blood after the kidneys have failed. The blood travels through tubes to a **dialyzer**, which removes wastes and extra fluid. The cleaned blood then flows through another set of tubes back into the body.

Impotence

The inability to produce an erect penis for sexual activity.

Peritoneal Dialysis

Cleaning the blood by using the lining of the belly (abdomen) as a filter. A cleansing solution, called **dialysate**, is drained from a bag into the belly. Fluids and wastes flow through the lining of the belly and remain “trapped” in the dialysate. The dialysate is then drained from the belly, removing the extra fluids and wastes from the body. *See also Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis.*

Peritoneal Membrane

A sac, resembling cellophane with holes, that serves as a lining of the abdominal cavity and holds organs in place within the peritoneal cavity.

Peritonitis

An inflammation of the **peritoneal membrane**. This inflammation causes an infection in the peritoneal membrane. Peritonitis is treated with antibiotics that are included in a special type of peritoneal dialysate.

Transplantation

The surgical procedure of placing a kidney from a donor to the recipient. There are three types of donations: cadaver, living related and living unrelated.

Urea Reduction Ratio (URR)

A blood test that compares that amount of **blood urea nitrogen** before and after dialysis to measure the effectiveness of the dialysis dose.

QUESTIONS I WANT TO ASK MY HEALTHCARE TEAM

1. _____

2. _____

3. _____

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8. _____

9. _____

10. _____

We would like to thank our AAKP Patient Plan[®] sponsors:

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