Otago Kidney Society Inc (OKS) – Winter edition

OKS newsletter

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Welcome to the Otago Kidney Society (OKS) Winter newsletter

President’s message

"With daylight savings and winter looming - welcome to the time of year where we all wrap up and stay cosy !

We would like to say a huge thank you to Blair Donkin who has left the position as charge nurse of the Dialysis unit - I am sure you will be missed , and good luck with your future endeavors.

We had World Kidney Day on March the 14th which was a great day with volunteer's chatting with the public raising awareness and taking blood pressures, it was a great success, big thank you to the nurse's for taking the time out from their busy schedule to do this.

Our AGM in March was a quiet affair but we managed to tick the boxes and make some plans around what might be happening later this year.

We also made it to Gore for a luncheon (of which at present we help subsidise these) , it was a great turnout with a few faces I had not yet met. We had lots of positive conversations with our wider kidney community.

We have a couple of great opportunities coming up - Dunedin Auto spectacular being one please come along and support us.

If you would like to join the OKS or have a hand in helping out we would love to hear from you.
Stay warm

James Blair"
President OKS

Events

Lunch in Gore in April

Otago Kidney Society Autumn Lunch – Sunday 7th April
At Thomas Green Public House & Dining Room, Gore
We had a great turnout yesterday with 22 people attending our lunch.
Liz had organised our own private room in the restaurant which made it easier to talk without background chatter from the other diners.
Once we were all seated, we each gave a brief introduction about ourselves and then it was time to order our meals.
There was a great vibe in the room as everyone chatted while they ate. Many people commented that it was lovely to meet other people in the same situation and they didn't feel so lonely/isolated now. It was interesting hearing people's stories too. The afternoon flew by and as we were leaving people commented that they wanted to meet up again.
I am reasonably new to the OKS luncheons, and I was struck by how important it is to have these so people can talk to others who understand. I think this is one of the most important events we can organise and I hope this encourages more people to come along.
By the way, the food was delicious too.
Thank you to everyone who came to our lunch and many thanks to Liz for organising it. Also thank you to the friendly, helpful Thomas Green staff.

Caroline & Steve

George, Donald and Lynda

James and Nobby

Karen and Diane

Karen, Diane and Jackie

Steve and George

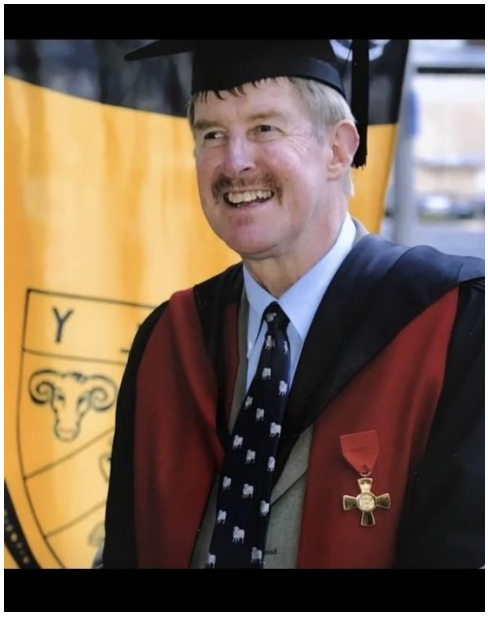
Stewart and Mel

Next Function

Our next luncheon will be held early August in Dunedin, a flyer will be sent out once arranged.

We are thrilled to announce that the Autospectacular Committee have selected The Otago Kidney Society as their charity for this year's event. The Autospectacular 2024 will be held on the 19th November and public entry will be from 9am to 4pm. More information to follow and we hope you will support this wonderful event.

Farewell to Dr Jock Allison



It was with much sadness that the news came through of Jock's passing. Jock was a president of the OKS and was a very active member, lobbying the

government on various issues. Many committee meetings were held at the Allison residence in Arthur Street with pizza and wine. We will miss your smiling face and catching up at the rugby, our condolences go to Hilary and the family and thank them for in lieu of flowers donations to the Kidney Society which raised $542, so even in passing he was still supporting us.

We have received 4 further donations this year (from 1st April 2024), totaling $1,270.39, so we thank those families involved and will make good use of these funds. We are looking to provide support to our members so any suggestions are very welcome.

New Dunedin Hospital
Whakatuputupu

Hi
My name is Natalie Brown, and I am the Treasurer for the Otago Kidney Society. I have also been appointed to the New Dunedin Hospital Build, Outpatient Building as a Consumer representative.
I was very honoured to be appointed to this position and would like to make sure I reach out to as many people in our community as possible to get their feedback on how we can take this opportunity to have the best possible experience visiting the new Outpatient Building.
This Consumer group does not have a say on the build as that has already been consulted on, but our brief is in the operation of the new building.
I would really appreciate if you could give me feedback on what is not good with the current outpatient experience and also what can be done to make this better, e.g. out of town patients have their appointments all on the same day to save travel.
The following are my details so please reach out to help make the best experience possible for all of us. I can come to you if that suits you better.
Ph 027 454 3512
Email natalie@windersbrown.co.nz
Many thanks Natalie

Ozempic Cuts Risk of Chronic Kidney Disease Complications, Study Finds

A major clinical trial showed such promising results that the drug's maker halted it early.

By Dani Blum Dani Blum has reported on Ozempic and similar drugs since 2022. May 24, 2024 Semaglutide, the compound in the blockbuster drugs Ozempic and Wegovy, dramatically reduced the risk of kidney complications, heart issues and death in people with Type 2 diabetes and chronic kidney disease in a major clinical trial, the results of which were published on Friday. The findings could transform how doctors treat some of the sickest patients with chronic kidney disease, which affects more than one in seven adults in the United States but has no cure. "Those of us who really care about kidney patients spent our whole careers wanting something better," said Dr. Katherine Tuttle, a professor of medicine at the University of Washington School of Medicine and an author of the study. "And this is as good as it gets." The research was presented at a European Renal Association meeting in Stockholm on Friday and simultaneously published in The New England Journal of Medicine. The trial, funded by Ozempic maker Novo Nordisk, was so successful that the company stopped it early. Dr. Martin Holst Lange, Novo Nordisk's executive vice president of development, said that the company would ask the Food and Drug Administration to update Ozempic's label to say it can also be used to reduce the progression of chronic kidney disease or complications in people with Type 2 diabetes. Diabetes is a leading cause of chronic kidney disease, which occurs when the kidneys don't function as well as they should. In advanced stages, the kidneys are so damaged that they cannot properly filter blood. This can cause fluid and waste to build up in the blood, which can exacerbate high blood pressure and raise the risk of heart disease and stroke, said Dr. Subramaniam Pennathur, the chief of the nephrology division at Michigan Medicine. The study included 3,533 people with kidney disease and Type 2 diabetes, about half of whom took a weekly injection of semaglutide, and half of whom took a weekly placebo shot. Researchers followed up with participants after a median period of around three and a half years and found that those who took semaglutide had a 24 percent

lower likelihood of having a major kidney disease event, like losing at least half of their kidney function, or needing dialysis or a kidney transplant. There were 331 such events among the semaglutide group, compared with 410 in the placebo group. People who received semaglutide were much less likely to die from cardiovascular issues, or from any cause at all, and had slower rates of kidney decline. Kidney damage often occurs gradually, and people typically do not show symptoms until the disease is in advanced stages. Doctors try to slow the decline of kidney function with existing medications and lifestyle modifications, said Dr. Melanie Hoenig, a nephrologist at Beth Israel Deaconess Medical Center who was not involved with the study. But even with treatment, the disease can progress to the point that patients need dialysis, a treatment that removes waste and excess fluids from the blood, or kidney transplants. The participants in the study were extremely sick — the severe complications seen in some study participants are more likely to occur in people the later stages of chronic kidney disease, said Dr. George Bakris, a professor of medicine at the University of Chicago Medicine and an author of the study. Most participants in the trial were already taking medication for chronic kidney disease. For people with advanced kidney disease, in particular, the findings are promising. “We can help people live longer,” said Dr. Vlado Perkovic, a nephrologist and renal researcher at the University of New South Wales, Sydney, and another author of the study. While the data shows clear benefits, even the researchers studying drugs like Ozempic aren’t sure how, exactly, they help the kidneys. One leading theory is that semaglutide may reduce inflammation, which exacerbates kidney disease. And the results come with several caveats: Roughly two-thirds of the participants were men and around two-thirds were white — a limitation of the study, the authors noted, because chronic kidney disease disproportionately affects Black and Indigenous patients. The trial participants taking semaglutide were more likely to stop the drug because of gastrointestinal issues, which are common side effects of Ozempic. Doctors said they wanted to know whether the drug might benefit patients who have kidney disease but not diabetes, and some also had questions about the potential long term risks of taking semaglutide. Still, the results are the latest data to show that semaglutide can do more than treat diabetes or drive weight loss. In March, the F.D.A. authorized Wegovy for reducing the risk of cardiovascular issues in some patients. And scientists are examining semaglutide and tirzepatide, the compound in the rival drugs

Mounjaro and Zepbound, for a range of other conditions, including sleep apnea and liver disease. If the F.D.A. approves the new use, it could drive even more demand for Ozempic, which has faced recurrent shortages. “I think it’s a game changer,” Dr. Hoenig said, “if I can get it for my patients.”
Dani Blum is a health reporter for The Times.

Update from the Dialysis Unit

Dialysis Service, Autumn, update May 2024.

Future Service planning.
I mentioned last time how well recognised it is that the current dialysis unit is well passed its anticipated lifespan (originally an interim refit with an approximate five-year life span) and that both from a facility and capacity perspective it is not adequate.
As the service does not feature, from a main facility perspective, in the New Dunedin Hospital Project whether it be the outpatient block or ward block, much effort has been made and continues to be made to find another site to develop further facilities here in Dunedin but also in Southland. This work is still at an early stage and while there is nothing definite to announce, please be assured that the need for these and other facilities is well recognised. This effort and work on the future model of care continue to be progressed and there will be more to be announced later this year, I hope.

Staff changes
Sadly Madhivanan Devaraj (RCP from Hawkes Bay) who joined us I August of 2023, had to return to India, early May, quite suddenly for personal reasons. Madhi will be missed, and this has created an unexpected vacancy which will take some time to fill. Another departure, not unexpected this time was Lein Aguila RN, leaving us to join her partner and family in Adelaide Australia. We had been expecting this for quite a while. Lein had been with us just over five and a half years and will be very much missed by all. Both Lein and Bronwyn’s vacancies remain unfilled now, but we hope that these will be appointed into in the very near future.

Related to this is the very real need for more allied health staff (dietitian, clinical psychology, and social work) support for those in the care of the

service. A lot of effort is being made to try and address this gap as well, but the challenge is the need exceeds the available workforce.

In the last newsletter we welcomed Kath Go into the role of (CNS PD) for Dunedin and we are very pleased to announce the appointment of Jo Harrison-Smith into the CNS PD role for Southland. Jo commences late May and will be in a training and development capacity as she learns about PD and the CNS role.

Early in April we welcomed Karen de Joux into the receptionist role. Karen comes with significant experience in the health sector having been practice manager for a dental centre in Auckland and involved with practice development and expansion. Karen has moved to Dunedin to be nearer family. We are very pleased to have Karen on the team and grateful for how well she has integrated into the team already and getting to grips with the role.

Charge nurse role – I also want to and need to let you all know that I have resigned from my position as charge nurse of dialysis for Southern. I finish on Friday May 31 after which I am on leave for just under a month and will then commence work with the infection prevention and control team.

My time (15 years) with the dialysis service has been an absolute privilege, utterly unique, and unlike any other role I have had. To have had the opportunity to work with so many of you and for the service to have benefited from the very much appreciated support of the OKS has been so very much appreciated. To every one of you who read this I want to express my very sincere thanks for your support, patience and understanding over the years. For your support and collaboration with the dialysis unit team here. It has been very much appreciated.

Carole Tinley RN will be covering the role for the month of June, after which arrangements are still to be confirmed.

I would like to take this opportunity to wish you all, the very best for the future.

Yours sincerely

Blair Donkin

Farewell to Blair – charge nurse manager – Dialysis unit 2009 – 2024 (15 years' of service)

Blair was interviewed by myself and Maree McDonald over the phone (no Teams back in 2009), he was up in CHCH at the time. He interviewed rather well, no surprises there (although he told us later he was a bit nervous). Blair moved back down to Dunedin with his family and became part of our dialysis team, or should I say family (Ann Donkin, Blair's wife, had worked in the dialysis unit back in 2003 - before my time).

He picked up dialysis quickly and was focused on quality improvement. He got the renal whiteboard (unit scheduler) and dialysis lab summary up and running – electronic monthly capture of patient's blood tests, increasing efficiency and reducing potential errors. While work life was busy, so was home life with a new baby becoming part of their whanau on temporary and then permanent basis – luckily Blair has good stamina and energy levels (we haven't managed to fatten him up though - despite our famous regular morning teas).

When Maree retired in 2013 Blair stepped up as associated charge nurse manager and then charge nurses manager.

It still amazes me how focused Blair can be with constant noise and "organized" chaos around him (especially the last 10 years having to sharing an office with me)! The staff numbers in our service have increased over the years, with more assisted dialysis required, as our patient population ages. We went from 9 to currently around 21 staff - with nurses working in Invercargill and out in the community in Dunedin, including Marne Street Hospital (that is a lot of nursing appraisals)! Blair has worked on various nephrology/dialysis working groups during his time here (Renal Society of Australasia Nursing Education Network / Chair of Nurse Advisory Group and nursing representative on the NRAB, national renal advisory board), as well as donating a day a fortnight at Servants Heath Service (as stated earlier – respect for stamina).

On a personal level and I am sure I speak for all the staff, when I say Blair has been a strong advocate for nurses and dialysis patients alike. He has our respect. Blair is fair above all else, professional, committed to improving

results through better processes and communication (all these attributes will serve him and his new team in infection control very well).

We will miss you Blair and are sad to see you go, but understand that this is your time for something new. You will always be welcome back for morning tea (especially if you bring your brownie).

Lynda – a colleague who has massive respect for you and who will miss you, even if you constantly desk shame me – unfortunately I think your interim replacement is even neater than you 😊

Best wishes from all the dialysis team

Dialysis in the 60s and 70s

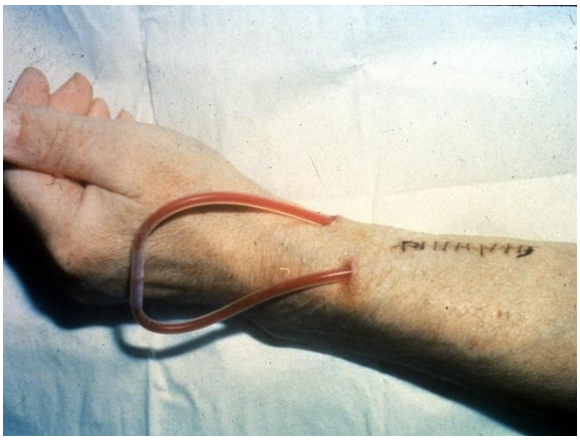
A Brief History: Liz Edwards retired dialysis nurse

In 1913, Leonard Rowntree and John Abel of Johns Hopkins Hospital developed the first dialysis system which they tested on animals. However, it was a doctor from the Netherlands, **Willem Johan Kolff**, who constructed the first working dialyser in 1943 during the German occupation of the Netherlands**.** Due to the scarcity of available resources, Kolff had to improvise and build the initial machine using sausage casings, drink cans, a washing machine and various other items that were available at the time. Over the following two years (1944–1945), Dr Kolff used his machine to treat 16 patients suffering from acute kidney failure, but the results were unsuccessful. Then, in 1945, a 67-year-old comatose woman regained consciousness following 11 hours of haemodialysis with the dialyser and lived for another seven years before dying from an unrelated condition. She was the first-ever patient successfully treated with dialysis.

The Dunedin Unit was opened on the 9th July 1970**,** but home training didn't start until 1974 following the appointment of Dr Anthony Hocken, an English nephrologist from East Yorkshire. Prior to that, Otago & Southland patients had to travel to Christchurch for training. No patients over 50 years of age were accepted onto the programme, or any with chronic diseases such as diabetes. However, you have to remember that resources were limited and the treatment was harsh - much less sophisticated than it is today. Older patients, or those with co-morbidities may not have survived the treatment. Also, the only option was haemodialysis at this stage. – peritoneal dialysis was only offered as an acute treatment initially. Pre-emptive transplants were definitely not an option.

My personal experience:

My first introduction to haemodialysis was as a 1st year student nurse on my very first ward, a women's general medical ward, at The Royal Sussex County Hospital in Brighton, England around April 1967. We had a couple of ladies with chronic renal failure, and they would have to be sponged and ready to go to our newly opened Dialysis Unit around 8.30am in the morning, & generally wouldn't arrive back until early evening after an 8 hour dialysis session. These patients were easily recognisable in those days as they had sallow complexions and they all had a tell-tale bandage wrapped around an arm or leg which was to protect their "shunt", or venous access. Attached to the bandage would be 2 "bull dog" clamps which never left the patient in case their shunt became disconnected and needed to be clamped quickly.



An arterio- venous shunt

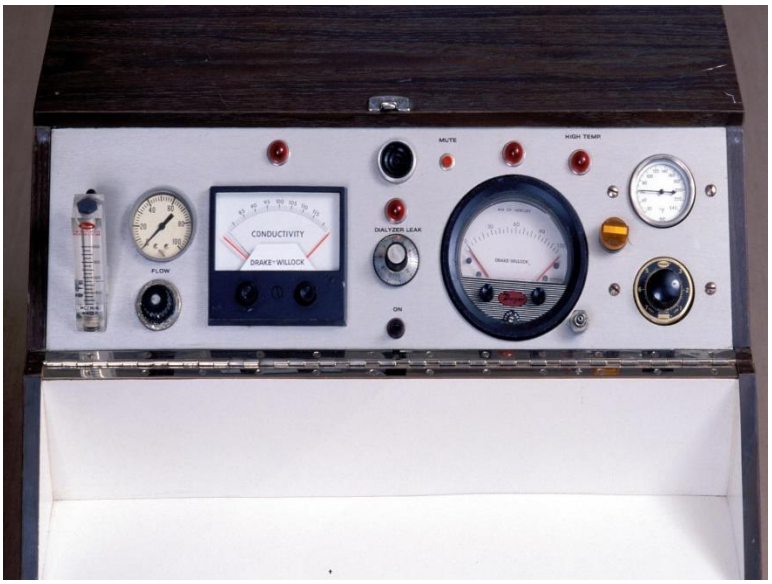
The shunt consisted of 2 lengths of silastic tubing, one end of which was inserted directly into an artery, & the other directly into a vein. When not in use for dialysis these 2 lengths of tubing were joined together by a small piece of Teflon to keep them patent. There were no central venous catheters, or neck lines used at this stage and though some patients had had fistulas constructed, many still dialysed via a shunt. Shunts were inserted for any patient requiring acute dialysis. They could become clotted, get infected around the insertion site, or worst case scenario fall out leading to massive blood loss, hence the need to bandage them to protect them from catching on items such as door handles.

There was no Erythropoietin (EPO) available in the 60s & 70s, so patients often had to function in daily life on haemoglobins of 60 -70g/L. Blood had to be preserved at all cost, especially as the extracorporeal volume was greater in those days. Dialysers were less efficient too, so patients were generally under dialysed.

Peritoneal dialysis was only offered as an acute treatment initially, and my only experience of that was as a 2nd year student nurse in the ICU to treat a lady with severe burns. The bags had to be kept warm on a radiator as there were no microwave ovens or specially designed heaters.

In December 1970, I went to the Royal Free Hospital in London to do a renal course which consisted of some lectures, but mostly lots of hands on learning in the dialysis unit. **There were no written manual instructions to follow. It was basically watch and learn, or "see one do one."** There were a group of patients who had been on dialysis for around 10 years, despite the less than ideal dialysis conditions, and they would tell stories of others less fortunate. A number of patients had good functioning fistulas, though there were still quite a lot with shunts and venous access was still a problem for many.

The haemodialysis proportionating machines were bigger and less user friendly than today, and alarm limits had to be set by hand. E.g. arterial and venous limits & conductivity limits. This would often lead to late detection of problems if limits set too wide apart. E.g. rising venous or low arterial pressures

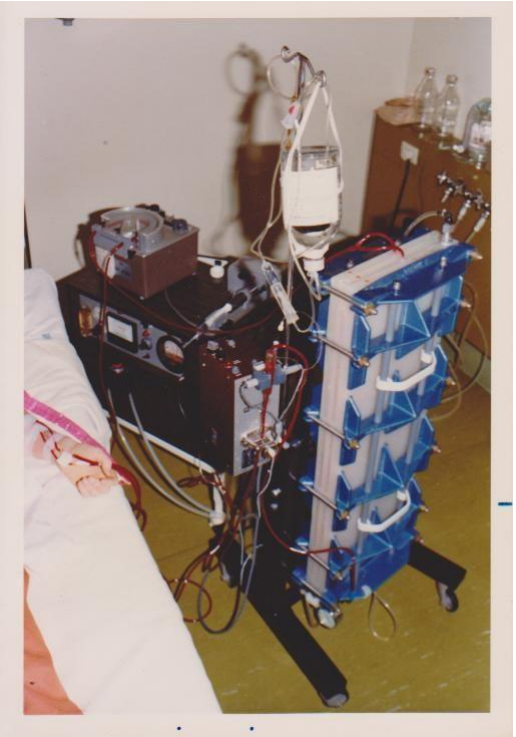


Alarms systems on Drake Willock machine – parameters had to be set manually once dialysis commenced

There was:
No alarm alert if the heparin pump had not been switched on - clotted blood circuits more common.
no timer to automatically turn the heparin pump off 30 minutes prior to completion of dialysis session
no alarm to advise that the dialysis session had finished – if you happened to be asleep you just got extra time. Otherwise you could set an alarm clock.

The desired amount of fluid to be removed could not be dialled in. Instead a formula was used to assess the probable amount of fluid that would be removed taking into account the patient's venous pressure and dialyser size/membrane pores. (coefficiency) If this would not produce enough fluid a negative pressure, or "suck", was applied by turning a knob at the front of the machine to make up the deficit. e.g. -50 to – 150. If too much was likely to be removed, sodium chloride was dripped into the arterial line over the course of the dialysis to prevent the patient "going flat".
Kiil dialysers were used but did not come out of a box ready to prime. They had to be built by the patient, and consisted of 3 boards with 2 layers of 2 sheets of cellulose placed between the 2 outer and middle boards and a blood port placed between the 2 layers at each end to which the blood lines would be attached. The dialyser had to be pressure tested once built, and if this test failed, it had to be stripped and the process begun again.
The lines were not streamlined like today. They had no identifying red or blue markers and no plastic clamps. Metal clamps were used to clamp off both the fistula needles and blood lines. The arterial line had to be cut so that an injection site, a short length of resealable rubber tubing, could be inserted between the cut to through which the heparin infusion was administered. There were no tightening devices on the ends of the lines so any joins were sealed with tape. Both the heparin pump and the blood pump sat separately on top of the machine rather than being built into it.

There were no bi-bags and no deionisers, no different sized dialysers or choice of dialysate solutions. **Dialysis was a "one size fits all".**
Patients commenced dialysis with the Kiil tipped at a 45degree angle (venous end uppermost) to expel air bubbles & once in dialysis mode the Kiil was placed flat. 30 minutes before wash back it was tipped with the venous end downwards at 90 degrees to encourage the RBCs downwards.


Kiil dialyser tipped ready for washback

The kiil dialyser was used three times before stripping and rebuilding. After completion of the 1st and 2nd dialysis sessions, the blood lines had to be rinsed with tap water from the patient end of the arterial line to the patient end of the venous line until clean and vice versa following washback. (? Around 10 minutes each way from memory), It was not unusual to have a flood on the floor if you forgot to release one of the clamps. Following this, the blood lines and dialyser were filled with a solution of formaldehyde to sterilise the blood circuit. This remained in place until the next dialysis session when the formaldehyde had to be rinsed out of the bloodlines with sodium chloride and a test performed to ensure that no traces of formaldehyde remained. If the test failed, more sodium chloride was put through the lines. (A small amount of fluid was run into a test tube & a tablet dropped into it. If the fluid turned orange, this indicated that formaldehyde was still present & extra rinsing was required whereas if it turned blue it had passed the test.)
The proportionating machine was also sterilised with formaldehyde solution for a specified time sequence, again a manual process. Prior to the next dialysis it too had to go through a rinsing process and then be tested manually to check that it was safe to use.

It was not uncommon for patients to have a reaction shortly after commencing a dialysis treatment. They would develop allergic type symptoms generally due to the agents used in sterilising the dialyser or bioincompatible membranes. The dialyser and blood circuit were rinsed with extra saline to try & eliminate this problem.

I later worked in the dialysis unit attached to The Royal Devon & Exeter Hospital, England in 1973 where hollow fibre dialysers were in use, a great relief as we no longer had to put them together! However, these too were used 3 times so had to go through the same process of rinsing and filling the blood lines & dialyser with formaldehyde solution. Besides Kiil dialysers, I also learned to use coil dialysers, an updated version of that which was devised by Dr Willem Kollf. The proportionating machine was like a big washing machine where the base was filled with water to a marked level on the side and a can of dialysate added. The machine was then put into a rinse or agitator mode to mix it. A small sample of the dialysate solution was then tested manually to check that it had mixed thoroughly & was at the correct concentration & therefore safe for the patient before it was gradually filtered through to an upper compartment into with the coil dialyser was placed, "the dialysate bath" and then primed. The dialysate solution only lasted for 4 hours so the base of the machine had to be refilled with fresh solution part way through the dialysis session, while the remaining solution in the upper compartment containing the coil had to be placed in recirculation during this time until safe to allow the replacement mixed & tested solution from the base to filter up.

After dialysis, the coil dialyser and blood lines and the proportionating machine had to go through the same rinsing and sterilising process as previously described.

Travenol Machine

Coil dialyser

Dialysate Fluid mixed & heated in lower chamber & filtered through to upper the chamber into which the coil dialyser was placed.

We also occasionally did acute peritoneal dialysis for about 8 hours via an early PD cycler machine.

I was pretty gob smacked when I started working in the unit here in Dunedin in the old hospital block in January 1976 to discover that Dr Tony Hocken, the nephrologist at the

time preferred the kiil dialysers so it was back to building again. However, the move to the new hospital in 1981 forced the change to hollow fibre dialysers due to the lack of foresight in the planning of the new unit (sound familiar?!) which consisted of a 4 bed patient room on 4C which had to accommodate four machines, 4 hospital beds, 4 dressing trolleys, a desk & a filing cabinet & various supplies scattered around the window sills. The bulk of supplies were stored in a spare room on the 6th floor. The sluice was shared with 4C & there was no room to store & build the Kiils, though we still had to reuse the dialysers & blood lines three times.

As you can see, major advances have taken place in the design of the proportionating machine and dialysers over the years to the stream lined machine with self-sterilising, multiple alarms/safety devices and accurate fluid removal that you use today. No more cutting of lines, and taping, or blood pumps and heparin pumps sitting separately on top of the machine. The introduction of EPO, patient appropriate dialysate and single use dialysers have all contributed to making patients lives a lot pleasanter as well as safer. We also have dedicated vascular surgeons and a lot more planning goes into the formation and timing of the creation of AV fistulas, though problems with the formation and maintenance of venous access is still an ongoing problem for some patients.
Patients no longer have to give up their bath to soak the boards of a Kiil dialyser, & the supplies are delivered to your door instead of having to collect them from the nearest hospital. Hazardous waste is also collected. Patients used to have to take their yellow bags to the nearest hospital to be disposed of.
I realise that despite all the changes dialysis is no picnic. It still takes up time, makes holidays more difficult, & the equipment takes up space in your house. However, just spare a thought for those patients from the 60s & 70s who paved the way for dialysis treatment today, many of whom didn't survive to reap the benefits of the advances made. I have the utmost admiration for them. **They were the real heroes.**

Some words of advice. Make the most of the opportunity that you've been given.
Don't live to dialyse. Dialyse to live Don't revolve your life around your dialysis sessions.

So those of you on haemodialysis have to dialyse 3 times per week, or in some cases 4. That leaves you 3 or 4 other days free.
Plan ahead & adjust your session times occasionally. That doesn't mean cutting your hours or skipping sessions. As long as you do the prescribed hours spread out throughout the course of the week & stick to your fluid allowance you will be fine, & life will be much more enjoyable Of course that will be much easier if you dialyse at home.
Those of you on peritoneal dialysis can still attend weddings, special occasions etc. Again, plan ahead & juggle your times slightly. Don't become too set in your ways & turn down invitations to meet friends, go on outings because of dialysis.
Don't make dialysis an excuse to miss out on things that you enjoy.

Finally, don't waste time sitting around waiting until you have a transplant to do all the things that you enjoy. Get on with living in the meantime.
Easy for me to say you may think. However, for those of you who don't know me, I spent most of my nursing career working in the dialysis unit and ironically my husband developed chronic renal failure in his late 50s & spent about 5 years on home haemodialysis while I was still working full time. We enjoyed days out and trips away, including a couple of long haul flights to visit family overseas, without ever compromising his dialysis treatment. All it needed was careful planning and sticking to the rules. That is, completing the prescribed weekly treatment hours and being careful with fluids. It's not rocket science.
I've known quite a number of patients who thought that they could bend the rules, skip treatments here and there and ignore their fluid restrictions. Sadly, they discovered that they couldn't, & many of them are no longer with us.

A kidney transplant isn't the only gift. **Dialysis is also a privilege** and fortunately it's free in New Zealand. Worldwide there are many patients who miss out on the opportunity to receive dialysis due to lack of availability and cost. My prospective mother-in-law, who I never got the opportunity to meet, died in her 40s in 1966 due to a lack of dialysis facilities in Dunedin at that stage.