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Peritoneal dialysis catheters – a more uniform surgical practice is needed

INVITERT KOMMENTAR

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A retrospective study of quality indicators provides valuable insights into surgical practices surrounding peritoneal dialysis catheter placements. There is an obvious need for clearer distribution of responsibilities and a more streamlined workflow.

In this issue of the Journal of the Norwegian Medical Association, Ruzic et al. present the results of a retrospective study of quality indicators for peritoneal dialysis catheter insertion at Oslo University Hospital in the period 2017–22 (1). The authors deserve praise for sharing valuable data on complication rates, catheter function and surgeon volumes.

In Norway, the use of peritoneal dialysis has fluctuated over time and figures vary between the regional health authorities. In 2012, those receiving peritoneal dialysis represented approximately 16 % of dialysis patients nationally (2). Following the introduction in 2017 of national targets to increase home dialysis, this proportion has gradually increased. In 2023, 24 % of Norwegian dialysis patients received peritoneal dialysis treatment at home (2). However, there are clear regional differences. The Directorate of Health reports that in the first four months of 2025, 27 % of patients received home dialysis (including home haemodialysis). The regional health authorities for Central Norway, Northern Norway, South-Eastern Norway and Western Norway report that their respective proportions are 20 %, 27 %, 32 % and 15 % (3). Of the 555 patients who started renal replacement therapy in the course of 2023, 55 % started on haemodialysis and 35 % on peritoneal dialysis while 10 % had a transplant without prior dialysis. This focus on catheter survival rates for peritoneal dialysis is therefore timely and will be important in the years ahead.

While nephrologists control the indications for peritoneal dialysis initiation as well as follow-up treatment, placing the dialysis catheter in the peritoneum is a surgical task. It is interesting to reflect on how the choice of surgical catheter placement technique appears to involve a balancing act between practical considerations and a desire to achieve the best possible patient outcome. Laparoscopic placement gives a better overview and higher precision, which may reduce complications and ensure correct placement of the catheter. Nevertheless, it is understandable that limited surgical resources and anaesthesia capacity at many hospitals will influence the choice of method.

In this context it is reasonable to ask how the principle of wise choice should be applied. Should the primary aim be to minimise the use of resources, or should we also be challenged to raise our ambitions when it comes to patient treatments? Choosing wisely is not only about doing less but about doing the right thing – for the individual patient, at the right time, using the right technique. Should an 80 % success rate be considered good enough? Is it right to allow organisational restrictions to define what is acceptable treatment? Should we not rather ask ourselves what is best for the patient, and if we should be aiming for a 95 % catheter survival rate as the norm rather than the exception. The argument that even a short period under general anaesthetic

represents a considerable risk for the patient is also debatable. For many, a 30–40-minute laparoscopic procedure will be completely safe – and for some, this may well provide the best outcome in the longer term.

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International guidelines for peritoneal dialysis recommend that the 30-day incidence of exit-site infection and peritonitis should both be below 5 % (4). This data gave an exit-site infection rate of 11 % and a 4 % incidence of peritonitis. The authors discuss how hard it is to differentiate between clinically positive infection and colonisation, or slight rubor, at the catheter exit-site. Catheter exit-site infections represent an important risk of peritonitis and catheter failure, and should be followed up, with a low intervention threshold, to ensure good catheter function and avoid having to stop the peritoneal dialysis (4). The most recent international guidelines have introduced clearer definitions for catheter-related infections and how they should be monitored, as well as more stringent recommendations on taking actions that may reduce early catheter-related infections (5, 6).

As peritoneal dialysis catheter placement does not fall within the natural remit of any of the main surgical specialties, it varies from hospital to hospital who performs this surgical procedure. In the study, a total of 78 surgeons performed 172 operations. Among the 16 lead surgeons, at least four had performed only one such procedure during training. More than half of them had performed fewer than two such operations per year while in training. Although discussions about surgical volume are difficult, it would be preferable to involve fewer surgeons than what is reported in this study. We assume that Oslo University Hospital was displeased with the results, because the hospital has already made changes to their surgical workflow (1). Unfortunately, there is little reason to believe that the situation is any different in Norway's other surgical units. This study should encourage surgical wards that perform this procedure, to reflect on their own practice.

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