

Varying Effects of Different Dialysis Techniques on End Stage Renal Disease Patients

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ABOUT THE STUDY

Chronic Kidney Disease (CKD) is expected to rise worldwide. The global prevalence of CKD reported in various researches varies. According to a 2016 comprehensive study, the global prevalence of CKD was 13.4%. End-Stage Renal Disease (ESRD), which has a significant mortality rate, is unavoidably caused by CKD. Dialysis is the most frequent treatment for ESRD patients who are unable to receive a kidney transplant. Dialysis is classified into two types: Hemodialysis (HD) and Peritoneal Dialysis (PD). Every patient's dialysis modality is selected after examining both medical and nonmedical considerations. A healthcare professional should do hemodialysis. Blood is pumped from the body to an artificial kidney mechanism in this type. The equipment draws blood, and then bathes it in a particular dialysate solution to remove waste substances and fluid before returning it to the patient's circulation. Hemodialysis is often conducted many times each week for 3-5 hours. Hemodialysis problems include muscle cramping and hypotension. Peritoneal dialysis involves inserting a catheter into the patient's abdomen, and the peritoneum functions as a natural filter. Unlike HD, PD does not require specialized inpatient equipment and may be performed at home. Dialysis is expensive for the healthcare system. According to a thorough analysis, the yearly average cost per patient for HD in low and middle-income nations is around \$30,079 and \$ 28,592.45 for PD.

The cost to society is diverse, including direct medical hospital, direct nonmedical, and indirect costs. Dialysis patients, in general, encounter a number of medical, psychological, and social challenges that might have long-term consequences. Sexual dysfunction, defined as a lack of or reduction in sexual desire and trouble with sexual arousal, discomfort during intercourse, or orgasmic dysfunction, whether biological or physiologic, is one of the neglected concerns. This is common in dialysis patients and varied from 41 to 93%, implying a multiple etiology, including hormonal imbalance, vascular and neurogenic dysfunctions, depression, and use of antihypertensive (i.e., beta-adrenergic antagonists and diuretics) and antidepressant medicines. Maintenance dialysis is a life-long therapy that is extremely likely to jeopardize a dialysis patient's career, familial, and

social standing. Furthermore, some studies imply that sexual dysfunction has a significant impact on Quality of Life (QoL), since changes in sexual activity alter a person's feeling of health. According to research, the two common dialysis procedures have varied impacts on a patient's sexual health. Furthermore, there is a significant variation between HD and PD procedures, and all of these elements may have varying effects on many parts of people's daily life. As a result, we wanted to assess the prevalence of sexual dysfunction among ESRD patients, both male and female, undergoing hemodialysis and peritoneal dialysis.

Sexual dysfunction is a major and common problem among CKD patients that has a negative impact on their quality of life. According to prior research, more than 80% of dialysis patients with chronic renal failure complain of erectile dysfunction, and a substantial percentage of women on dialysis have decreased sexual function. Some conditions are linked to erectile dysfunction in males. Unlike in males, sexual dysfunction in women is subjective and more convoluted, making therapy difficult. We compared sexual function in two groups of HD and PD patients to acquire a more comprehensive picture and evaluate sexual dysfunction among CKD patients. Few researches have examined sexual dysfunction in HD and Parkinson's disease patients. According to Wu, after a year, patients on HD showed superior sexual function than those on PD. Furthermore, Guan demonstrated that the prevalence of SD was comparable in individuals with HD and PD. Furthermore, Basok discovered that the frequencies of sexual dysfunction in PD and HD patients were around 81% and 67%, respectively. Sexual dysfunction in dialysis patients has a complicated pathophysiology. Additional investigation will be required to examine more physiologic, social, and psychological characteristics in dialysis patients in order to acquire a more complete understanding of this occurrence. Notably, future investigations in these individuals must consider dependable and specialized instruments. For example, the connection of hbA1c with glycemic management is being questioned in both hemodialysis and peritoneal dialysis patients, implying that clinicians must make multiple changes to accurately interpret hbA1c results. Furthermore, no sexual dysfunction questionnaire has been developed exclusively for dialysis patients. So far, in-line

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studies have used generic questionnaires such as the FSFI, SF-36, CHEQ ("CHOICE study" Health Experience Questionnaire containing SF-36 and 14 dialysis-specific areas), and IIEF. Both simplified and extended customized questionnaires should be developed for future research investigations and therapeutic applications. Sexual dysfunction is common in both male and female CKD patients being treated with HD and PD. Dialysis patients face a variety of issues, including dietary limitations, financial difficulties, sexual dysfunction, marital concerns, and

changes in their personal duties. These issues, particularly sexual dysfunction, have an impact on patients' quality of life. Given that dialysis is a life-long treatment, the healthcare system must take this aspect of a patient's life seriously. We should strive to select the best strategy for each patient based on their personality and particular circumstances. Healthcare services should be alert to recognize this problem in dialysis patients and work to enhance patients' sexual function through the use of appropriate therapies.