KI REPORTS
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Pregnancy Counseling for Patients With Kidney Disease: Moving Toward a Person-Centered Approach

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Kidney Int Rep (2023) **8,** 2504–2506; https://doi.org/10.1016/j.ekir.2023.10.024

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Because of the complexities of pregnancy in patients with chronic kidney disease (CKD), it is important for individuals to be well-informed and receive appropriate medical care and guidance. Inadequate discussion and planning for pregnancy can lead to suboptimal care for patients with CKD, potentially increasing the risk associated with pregnancy.[1] This can lead to delayed intervention if any complication occurs and additional stress and anxiety for patients.[2] Despite this clinical need, nephrologists endorse a lack of confidence in their own experience with counseling and management of many aspects of reproductive health care.[3-5] It has been almost 10 years since this topic has been identified as a high priority area for nephrologist and patient education, but there are still significant gaps in care.

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In a recent issue of KI Reports, Oliverio *et al.*[6] and Hewawasam *et al.*[7] have published 2 studies that provide contemporary insight into the pregnancy counseling experiences of patients with CKD, their partners, and their kidney specialists. These studies outline key areas for the nephrology community to focus their educational initiatives to better support patients with CKD who are considering pregnancy and we have summarized their findings and suggestions into a conversation framework for nephrologists (Figure 1).

Oliverio *et al.*[6] have performed a semiqualitative interview study of 30 patients aged 18 to 45 years old with CKD stage 1 to 5 and 12 nephrologists from a single academic medical center in the United States. Both patients and nephrologists disclosed that discussions about future pregnancy, contraception, and overall reproductive health were infrequent. Like previous studies, the participants highlighted a desire for nephrologists to routinely initiate counseling on reproductive health care. Importantly, patients noted that their reproductive intentions may change over time and are influenced by changes to their health status, relationship, and social circumstances as well as from counseling from providers. For participants with intentions of future pregnancy, fear, and inadequate information about CKD and reproductive health were identified as major challenges. Nephrologists also struggled with risk communication, trying to provide accurate estimates of risk without conveying negativity or being dismissive. Finally, the respondents highlighted the importance of pregnancy counseling, because misinformation led to unintended pregnancies and complications, which are potentially avoidable scenarios.

Hewawasam *et al.*[7] completed a cross-sectional survey of 102 women with CKD from Australia along with 17 of their partners. Questions were concentrated on the following: (i) demographic data, kidney disease, and comorbidities; (ii) experiences of pregnancy-related discussions; (iii) preferences for pregnancy-related counseling and education/information; and (iv) overall participant satisfaction and feedback. Strengths of their survey include that it was developed with patient partners and has geographic representation from across the country. Again, they observed significant room for improvement with reproductive health counseling. Only a quarter of respondents felt that they had sufficient knowledge about pregnancy with kidney disease and most women had to initiate conversations about their reproductive health with their nephrologists. In a significant proportion of women (15%), conversations about pregnancy only occur after conception, thus identifying this as an ongoing

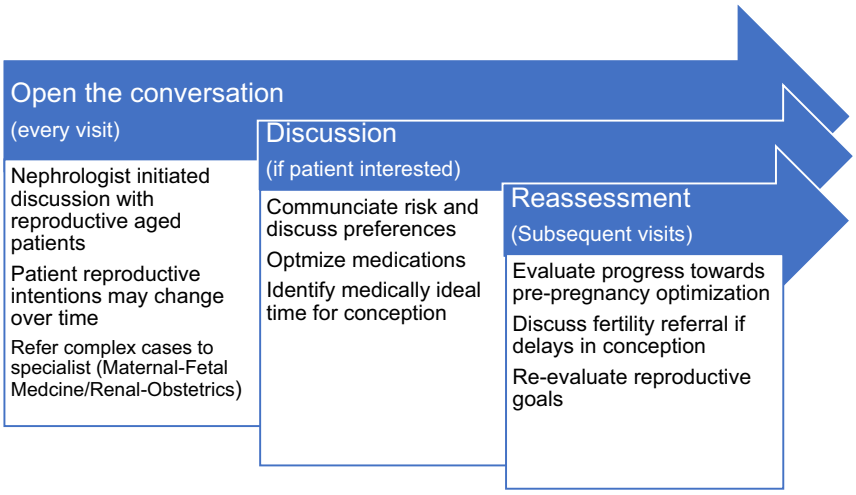

Figure 1. Incorporating pregnancy counseling into nephrology practice.

area for improvement. Those who did have discussions with their nephrologists did find information satisfactory and useful about half of the time. Women had a strong preference for specialist (nephrologist or obstetrician) counseling as opposed to a family physician or the internet. Although the partners of patients were also included in this study, the numbers were too low to draw any significant conclusions and can be considered as an area for future research.

These studies add to a growing body of literature in women's health that call for further training and resources for nephrologists.[1,2,4] The themes identified in these studies are consistent with those previously reported: patients desire nephrologist-led conversations that convey risk, provide opportunities for optimization, and allow patients to make autonomous and informed decisions. Patients require disease and medication specific counseling that can only be provided by a nephrology care provider. The consequences of inadequate counseling include unintended pregnancies, higher rates of pregnancy complications and missed opportunities for childbearing. These consequences can have multigenerational physical and psychological impacts.

A framework for pregnancy counseling is included in Figure 1, and highlights an approach that nephrologists might find useful to adapt to their practice. First, a nephrologist should ask patients of reproductive age if they have interest in discussing pregnancy. If a patient is interested, the nephrologist can either provide counseling in the moment, book another appointment to discuss at a future date, or refer the patient to a nephrologist with interest or training in pregnancy (which can often be done virtually). Second, when discussing pregnancy, the nephrologist should discuss patient-specific risk, optimize medications, and identify a medically ideal time for conception for the patient (e.g., waiting until at least 1 year post transplant or until glomerular disease has been quiescent).[1,8] Finally, the nephrologist should check in and reassess at subsequent visits considering that a patient's reproductive desires may change over time and patients who are experiencing delayed conception may benefit from a fertility assessment by a reproductive endocrinologist or obstetrician.

There are still key areas that should be addressed with future studies. Although Oliverio's study included 50% non-White patients (Hewawasam *et al.*[7] does not report ethnicity and race data), no study to date has considered intersectionality with regard to pregnancy and family planning. There are many factors, including patient ethnicity, race, socioeconomic background, education level, and gender that impact expectations about reproductive health discussions and the potential desire for pregnancy. Further qualitative studies with an intersectional lens are required to explore this topic. We must also consider that the gender of the health care provider may also play a role in the perception of discussions around pregnancy. Finally, the current literature focuses on patients from developed nations with adequate resources for supporting high risk pregnancies. Pregnancy risk counseling would be very different in a lower-resourced setting where there may not be access to high risk obstetrical and neonatal care or to kidney replacement therapy for all patients.

We need to move beyond the identification of challenges with reproductive health care counseling and start to think of creative and accessible solutions to empower nephrologists to have these discussions. An online risk calculator could be developed using published data on pregnancy outcomes to help guide nephrologists through pregnancy risk discussions. Alternatively, the advent of telehealth has made access to specialized care more accessible and nephrologists with an interest in women's health can offer virtual pregnancy counseling and medication optimization consults. Ultimately, the first step is simple: we cannot use any of these tools if we do not first ask our patients: Are you interested in having a conversation about pregnancy today?

DISCLOSURE

EH has received consultancy fees from Paladin Labs Inc. NP has declared no competing interest.

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