

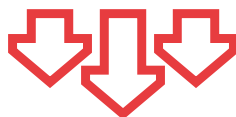


Management of Diabetic Kidney Disease

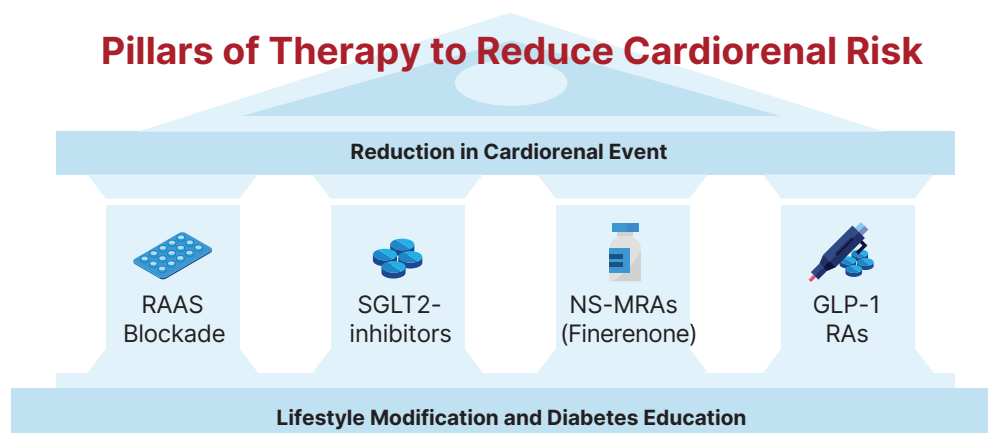
Why Manage?

 **Decreases risk of
CKD progression**

 **Cardiovascular
risk reduction**



Pillars of Therapy to Reduce Cardiorenal Risk



Pharmacological Agents

**ACE inhibitor
or an ARB**

SGLT2-inhibitors

(for people with type 2 diabetes with CKD + estimated glomerular filtration rate ≥ 20 mL/min/1.73 m² with normal or elevated urinary albumin)

GLP-1 RAs

(for additional cardiovascular risk reduction)

NS-MRAs

(shown to be effective in clinical trials (if estimated glomerular filtration rate is ≥ 25 mL/min/1.73 m² in people with CKD and albuminuria who are at increased risk for cardiovascular events or CKD progression)

Clinical tips

- Periodically check serum creatinine and potassium levels when ACE-inhibitors, ARBs, and MRAs are used.
- Do not discontinue ACE-inhibitors or ARB for $\leq 30\%$ increases in serum creatinine in the absence of volume depletion.
- Aim for a reduction of 30% or greater in mg/g urinary albumin in people with chronic kidney disease who have ≥ 300 mg/g urinary albumin to slow chronic kidney disease progression.

ACE-inhibitor = Angiotensin-converting enzyme inhibitors
ARB = Angiotensin receptor blocker
SGLT2-inhibitors = Sodium-glucose cotransporter 2 inhibitor

GLP-RAs = Glucagon-like peptide 1 agonists
NS-MRAs = Nonsteroidal mineralocorticoid receptor antagonists
CKD = Chronic kidney disease