ADA/KDIGO consensus report – early diagnosis helps optimise CKD care

A new consensus report on diagnosis and management of chronic kidney disease (CKD) in people with diabetes from the ADA and KDIGO highlights the importance of using both eGFR and ACR biomarkers to ensure early diagnosis, thus allowing optimal use of newer therapies to slow progression of renal decline and reduce the significantly increased risk of cardiovascular disease and death. The consensus identifies areas of agreement between the separate guidance provided previously by the two groups. Clinicians are encouraged to help people optimise nutrition, exercise, smoking cessation and weight, to use evidence-based therapies to optimise organ protection (kidney and heart), and to help people with diabetes attain glycaemic, blood pressure and lipid targets. In so doing, the route map provided by the consensus report is expected to lead to more consistent and improved outcomes for people living with diabetes and CKD.

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A new consensus report on diagnosis and management of chronic kidney disease (CKD) in people with diabetes from the American Diabetes Association (ADA) and Kidney Disease: Improving Global Outcomes (KDIGO) group has been published. The consensus identifies areas of agreement between the separate guidance provided previously by the two groups. In so doing, the route map provided by the consensus report is expected to lead to more consistent and improved outcomes for people living with diabetes and CKD.

Consensus statements

Both the ADA, in the CKD section of their *2022 Standards of Medical Care*, and the KDIGO group, in their *2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease*, make recommendations on the diagnosis and management of people with diabetes and CKD (ADA, 2022; KDIGO Diabetes Work Group, 2022). Each group has focused on this from its own speciality starting point, and the consensus group aimed to identify and share areas of agreement between the two sets of guidance. These are summarised here:

- Start CKD screening 5 years after diagnosis of type 1 diabetes and at diagnosis of type 2 diabetes.
- Use both eGFR and albumin:creatinine ratio (ACR) biomarkers to look for CKD in those with diabetes. Diagnose CKD either if eGFR is <60 mL/min/1.73 m^2 and/or if ACR is ≥30 mg/g (≥3 mg/mmol), **persisting for at least 3 months**. Other markers of kidney damage, such as haematuria or structural abnormalities, may also be present.
- Optimise nutrition, exercise, smoking cessation and weight, then layer evidence-based pharmacotherapies to preserve organ (heart and kidney) function, and attain glycaemic, blood pressure and lipid targets.
- Recommend a diet high in vegetables, fruits and whole grains, low in refined carbohydrates and low in sugar-sweetened beverages. Recommend a low-sodium diet (KDIGO: <2000 mg/day, ADA: 1500–2300 mg/day) to help control blood pressure and decrease CVD risk. Recommend a protein intake of 0.8 g/kg/day: same as in the normal population (protein 1.0–1.2 g/kg/day if on maintenance dialysis).
- ACE inhibitors or ARBs are recommended for those with type 1 or type 2 diabetes who have hypertension and albuminuria, titrated to the maximum tolerated licensed dose. If no albuminuria, offer a dihydropyridine CCB (e.g. amlodipine) or a thiazide diuretic. Several drugs may be required to optimise blood pressure control.

Citation: Brown P (2022) Diabetes Distilled: ADA/KDIGO consensus report – early diagnosis helps optimise CKD care. *Diabetes & Primary Care* **24**: [early view publication]

"The holistic nature of the consensus recommendations highlighted here, including the importance of lifestyle advice, the benefits of modern drug therapies over and above their glucose-lowering abilities, and recognition of the need for multiple reviews to avoid therapeutic inertia and ensure safe implementation of these drug classes, are important take-home messages for us in primary care."

- Statins are recommended for everyone with diabetes and CKD:
  - Moderate-intensity (atorvastatin 10 mg, rosuvastatin 5 mg, simvastatin 20–40 mg) for primary prevention of atherosclerotic CVD.
  - High-intensity (rosuvastatin 10 mg, atorvastatin 20 mg or greater) if known atherosclerotic CVD and for some people with multiple risk factors (**note:** this differs from NICE guidance).
- Metformin is recommended for those with type 2 diabetes, CKD and an eGFR ≥30. Reduce dose to 1000 mg daily if eGFR is 30–44 (and in people with eGFR 45–59 at high risk of lactic acidosis).
- An SGLT2 inhibitor with proven renal or cardiovascular benefits is recommended in people with type 2 diabetes, CKD and eGFR ≥20, **even if glycaemic targets are already met**. Once initiated, it can be continued at lower eGFR.
- A GLP-1 receptor agonist with proven CVD benefit is recommended for people with type 2 diabetes and CKD who do not meet glycaemic targets with metformin and/or an SGLT2i, or are unable to use these drugs.
- Dose adjustments, initiation and stopping thresholds for drugs are different from those in the UK product licences – consult the UK Summaries of Product Characteristics for the drugs, the BNF or *Diabetes & Primary Care*'s Need to know guide.
- A non-steroidal mineralocorticoid receptor antagonist (finerenone) with proven kidney and cardiovascular benefits is recommended for those with type 2 diabetes, eGFR ≥25, normal potassium (<5.0 mmol/L) and albuminuria ≥30 mg/g (3 mg/mmol) despite the maximum tolerated dose of a RAS inhibitor.
  - Currently, this will usually be commenced by specialist teams.
  - Start 10 mg daily if eGFR is 25–60, and uptitrate to 20 mg if possible. If eGFR is >60, start at 20 mg.
  - Check potassium levels at 4 weeks after dose change and regularly during treatment. If potassium is <4.8 mmol/L, can increase to 20 mg and continue provided potassium is ≤5.5 mmol/L. If potassium is >5.5 mmol/L, stop and reintroduce at 10 mg once potassium is <5.0 mmol/L.
  - Can be continued at eGFR <25 if potassium levels are OK and otherwise tolerated.

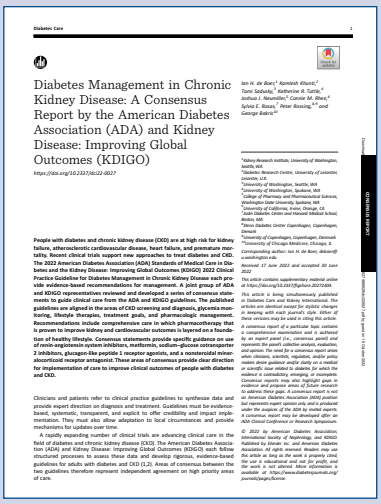
Concluding remarks

Following the pandemic, primary care teams are again able to be more proactive in diagnosing and managing people with CKD, and we are aware that people with diabetes and CKD are at high risk of CVD and premature cardiovascular mortality, as well as CKD progression if they survive long enough. The recent increased focus on assertive lipid management in those with CKD is a useful reminder.

The holistic nature of the consensus recommendations highlighted here, including the importance of lifestyle advice, the benefits of modern drug therapies over and above their glucose-lowering abilities, and recognition of the need for multiple reviews to avoid therapeutic inertia and ensure safe implementation of these drug classes, are important take-home messages for us in primary care. ■

American Diabetes Association (2022) 11. Chronic Kidney Disease and Risk Management: Standards of Medical Care in Diabetes – 2022. *Diabetes Care* **45**(Suppl 1): S175–84

Kidney Disease: Improving Global Outcomes (KDIGO) Diabetes Work Group (2022) KDIGO 2022 clinical practice guideline for diabetes management in chronic kidney disease. *Kidney Int* **102**(Suppl 4): S1–123



Diabetes Management in Chronic Kidney Disease: A Consensus Report by the American Diabetes Association (ADA) and Kidney Disease: Improving Global Outcomes (KDIGO)

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