

Guidelines for Diabetes with Dyslipidemias 2015

Recommendations

Optimize glucose control to reduce the risk or slow the progression of diabetic kidney disease. **A**

Optimize blood pressure control to reduce the risk or slow the progression of diabetic kidney disease. **A**

Screening	Treatment Recommendations and Goals
<p>At least once a year, quantitatively assess urinary albumin (e.g., urine albumin-to-creatinine ratio [UACR]) and estimated glomerular filtration rate (eGFR) in patients with type 1 diabetes duration of ≥ 5 years and in all patients with type 2 diabetes. B</p>	<p>An ACE inhibitor or angiotensin receptor blocker (ARB) is not recommended for the primary prevention of diabetic kidney disease in patients with diabetes who have normal blood pressure and normal UACR (< 30 mg/g). B</p>
	<p>Either an ACE inhibitor or ARB is suggested for the treatment of the non-pregnant patient with modestly elevated urinary albumin excretion (30–299 mg/day) C and is recommended for those with urinary albumin excretion > 300 mg/day. A</p>
	<p>When ACE inhibitors, ARBs, or diuretics are used, monitor serum creatinine and potassium levels for the development of increased creatinine or changes in potassium. E</p>
	<p>Continued monitoring of UACR in patients with albuminuria is reasonable to assess progression of diabetic kidney disease. E</p>
	<p>When eGFR is < 60 mL/min/1.73 m², evaluate and manage potential complications of chronic kidney disease (CKD). E</p>
	<p>Consider referral to a physician experienced in the care of kidney disease when there is uncertainty about the etiology of kidney disease, difficult management issues, or advanced kidney disease. B</p>
<p>Nutrition</p>	<p>For people with diabetic kidney disease, reducing the amount of dietary protein below the recommended daily allowance of 0.8 g/kg/day (based on ideal body weight) is not recommended because it does not alter glycemic measures, cardiovascular risk measures, or the course of GFR decline. A</p>