Professional version

American Diabetes Association®

Guidelines InSIGHT
Your visual guide to the guidelines

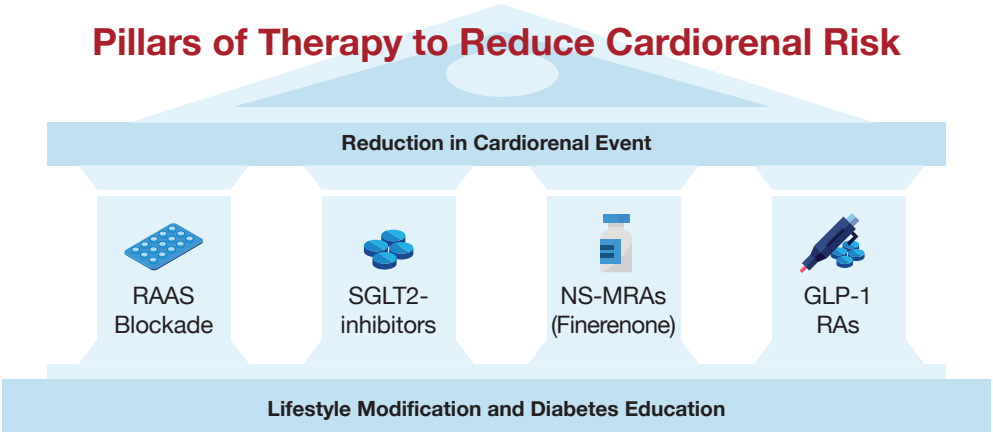
Learn more about
Diabetic Kidney Disease

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

GLP-1 RAs
(for additional cardiovascular risk reduction)

SGLT2-inhibitors
(for people with type 2 diabetes with CKD + estimated glomerular filtration rate ≥20 mL/min/1.73 m^2 with normal or elevated urinary albumin)

NS-MRAs
(shown to be effective in clinical trials (if estimated glomerular filtration rate is ≥25 mL/min/1.73 m^2 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 ≤ 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

This infographic is based on recommendations from the ADA's *Standards of Care in Diabetes—2023*