

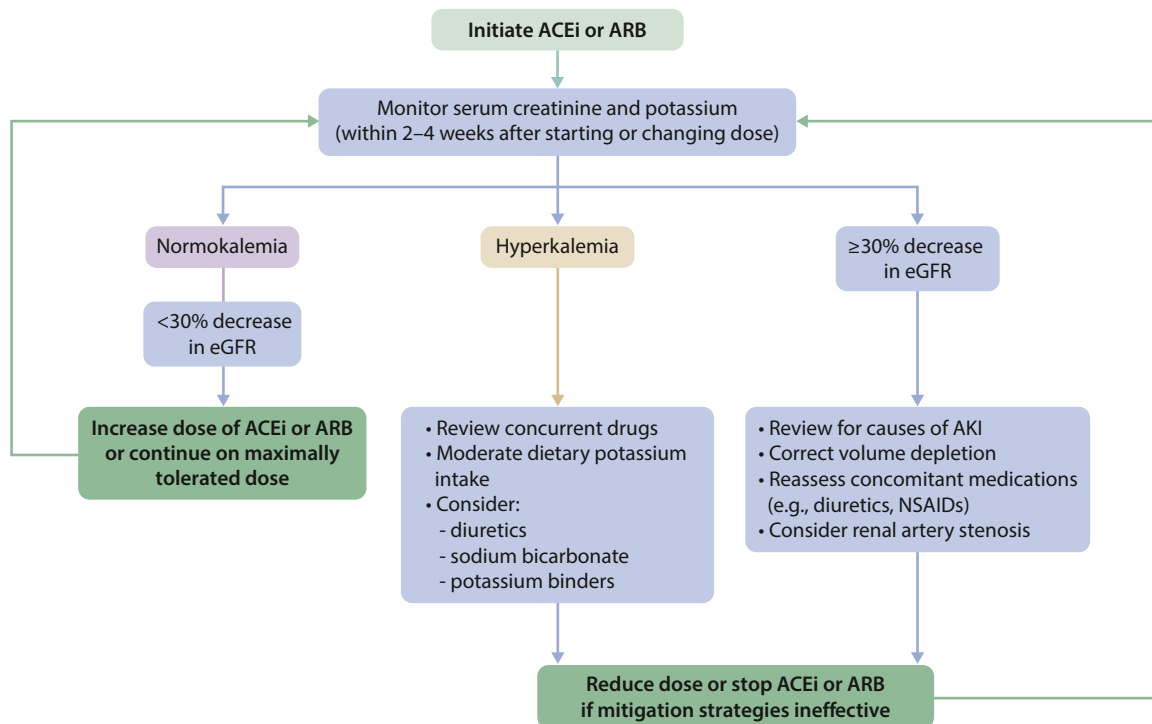


Figure 21 | Algorithm for monitoring of potassium and estimated glomerular filtration rate (eGFR) after the initiation of renin-angiotensin system inhibitors. ACEi, angiotensin-converting enzyme inhibitor; AKI, acute kidney injury; ARB, angiotensin II receptor blocker; NSAID, nonsteroidal anti-inflammatory drug. Modified from Kidney Disease: Improving Global Outcomes Diabetes Work Group. KDIGO 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease. *Kidney Int.* 2022;102:S1–S127.²³ Copyright © 2022, KDIGO: Kidney Disease Improving Global Outcomes. Published by Elsevier Inc. on behalf of the International Society of Nephrology. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

eGFR <30 ml/min per 1.73 m², compared with those who continue.^{508,509} In addition, a recent individual patient level data meta-analysis demonstrated a benefit in delaying KRT in patients with eGFR <30 ml/min per 1.73 m².⁵¹⁰

3.7 Sodium-glucose cotransporter-2 inhibitors (SGLT2i)

The Work Group concurs with the KDIGO 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease, which stated: “We recommend treating patients with type 2 diabetes (T2D), CKD, and an eGFR ≥20 ml/min per 1.73 m² with an SGLT2i (1A).”²³ However, in this guideline, we offer a more general 1A recommendation for adults with CKD. We also highlight practice points from the KDIGO Diabetes guideline for diabetes management in CKD, which are also relevant for people with CKD without diabetes:

Recommendation 3.7.1: We recommend treating patients with type 2 diabetes (T2D), CKD, and an eGFR ≥20 ml/min per 1.73 m² with an SGLT2i (1A).

Practice Point 3.7.1: Once an SGLT2i is initiated, it is reasonable to continue an SGLT2i even if the eGFR falls below 20 ml/min per 1.73 m², unless it is not tolerated or KRT is initiated.

Practice Point 3.7.2: It is reasonable to withhold SGLT2i during times of prolonged fasting, surgery, or critical medical illness (when people may be at greater risk for ketosis).

Recommendation 3.7.2: We recommend treating adults with CKD with an SGLT2i for the following (1A):

- eGFR ≥20 ml/min per 1.73 m² with urine ACR ≥200 mg/g (≥20 mg/mmol), or
- heart failure, irrespective of level of albuminuria.

Practice Point 3.7.3: SGLT2i initiation or use does not necessitate alteration of frequency of CKD monitoring and the reversible decrease in eGFR on initiation is generally not an indication to discontinue therapy.

Use of SGLT2i in people with T2D is recommended in previous guidelines irrespective of level of albuminuria. This new recommendation (3.7.2) places high value on the importance of reducing risk of kidney failure, cardiovascular mortality, and heart failure in people with CKD and high value on the large relative reductions in risk for kidney disease progression in a series of large, placebo-controlled RCTs. It also places moderate value on the benefits of SGLT2i on risk of AKI, hospitalization for heart failure and myocardial infarction, risk of hospitalization from any cause, and high value on the demonstrable net absolute benefits versus absolute harms in people with CKD (particularly in those