

to health.⁽³⁾ Multiple observational reports in CKD have explored the association between dietary potassium intake and outcomes; in a majority, surrogates of high potassium intake were associated with a lower risk of death or progression of kidney disease. In addition, observational studies in persons with CKD or ESKD report weak associations between dietary potassium intake and potassium concentration.⁽²⁷⁷⁾

Finally, given the association of cardiovascular outcomes with CKD related mineral bone disease, it is also reasonable to recommend a low inorganic phosphorus (i.e., phosphorus additives in processed packaged foods) diet for patients with evidence of progressive CKD.

Individuals with multiple co-occurring conditions are at a higher risk for malnutrition particularly with pharmacologic treatment. The use of GLP-1 RA combined with SGLT2i in individuals with CKD may require careful monitoring for muscle wasting and the need for additional protein consumption.⁽³⁸⁷⁾ Conversely, protein restriction may be reasonable for individuals whose protein consumption is deemed to be more than nutritional needs. Consider a referral to a renal dietitian for assessment and education regarding appropriate protein intake. Patients should be screened frequently for evidence of acute and/or chronic malnutrition using the six Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition (ASPEN) clinical criteria and further assessed and treated if screening is positive.^(388,389)