

Clinical Challenges in Diabetes Management

Case-based discussion

- A 62-year gentleman was referred to a nephrology clinic due to proteinuria and azotemia
- He is a case of T2DM for 14 years and history of HTN for 6 years

Lab Data

Serum creatinine was 1.5 mg/dl last year

Proteinuria was 1+ last year

Now, serum creatinine rises to 2.1 mg/dl

Urea: 88 mg/dl

24 hours urine protein = 500 mg

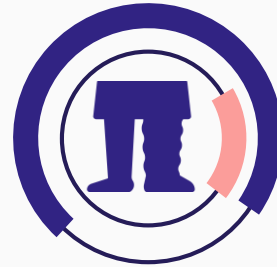
HbA1C = 7.0%

Physical Examination



BP

160/95



Leg Edema

+1

Drug History

Metformin

1000 mg BD

Glibenclamide

20 mg daily

Atorvastatin

20 mg daily

ASA

80 mg daily

Furosemide

40 mg BD (started 3 weeks ago
due to leg edema)

Pioglitazone

30 mg (started 2 months
ago)

What do you recommend for better management of DKD?

- A) Discontinue pioglitazone and furosemide
- B) Add empagliflozin
- C) Discontinue Metformin, pioglitazone and adjust Glibenclamide dosage
- D) Discontinue all of OHA (Orally administered antihyperglycemic agents) and start linagliptin 5 mg daily and gliclazide 80mg daily
- E) Consider empagliflozin after treatment of pre-renal azotemia