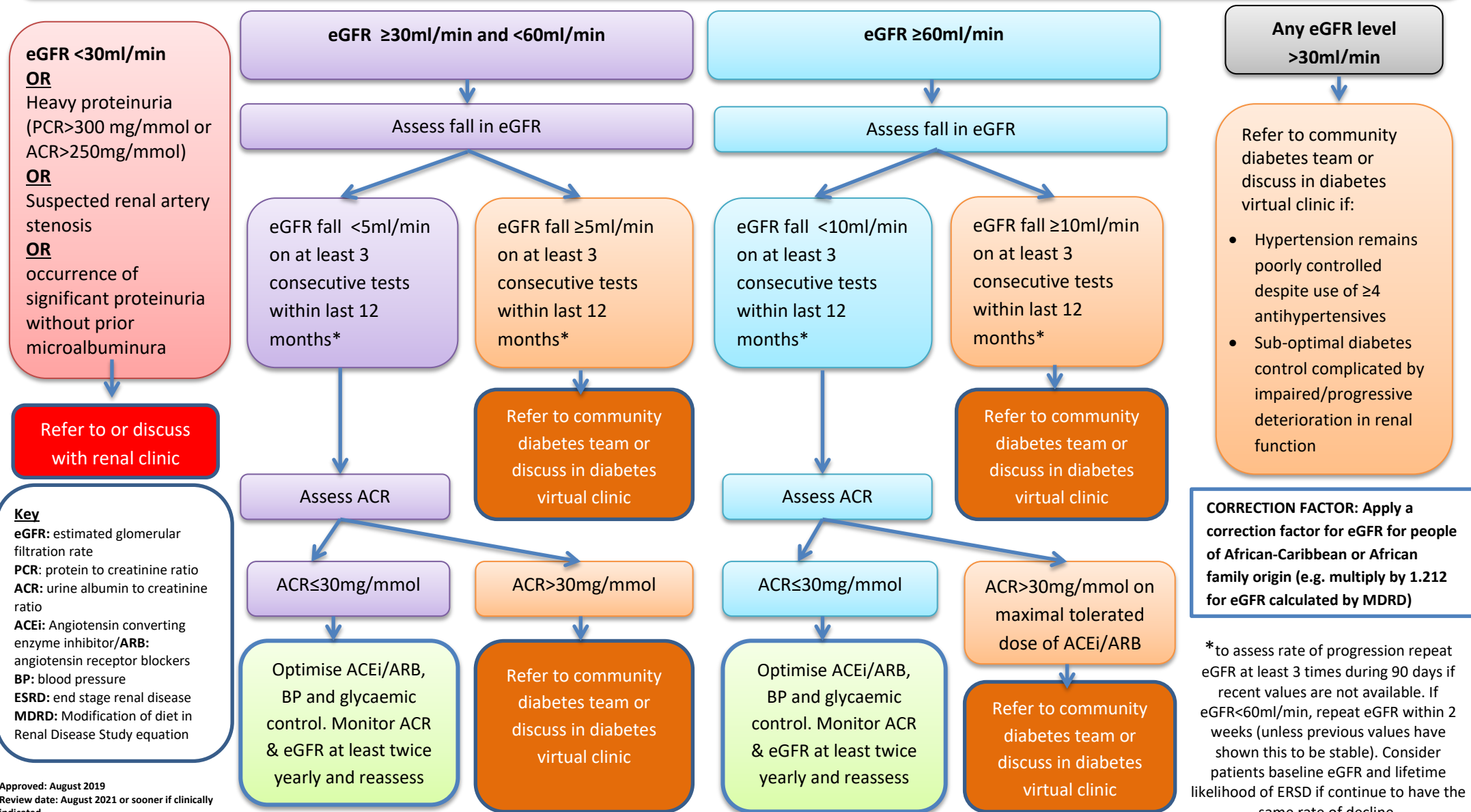


Referral pathway for patients diagnosed with Type 2 diabetes and diabetic kidney disease (DKD) based on progression (rate of eGFR fall) or degree of albuminuria

NOTE: This pathway is for patients with Type 2 diabetes and diabetic kidney disease. For all suspected cancer, investigation of haematuria, outflow obstruction or known or suspected autoimmune or genetic causes of CKD or patients without Type 2 diabetes, please see local/national renal guidelines



Referral pathway for patients diagnosed with Type 2 diabetes and diabetic kidney disease (DKD) based on progression (rate of eGFR fall) or degree of albuminuria

Additional information

Target blood pressure for people with Type 2 diabetes with kidney, eye or cerebrovascular damage:

<130/80mmHg

Risk factors for DKD progression

- Younger age of onset of T2DM
- Duration of diabetes
- Poorly controlled diabetes
- Co-existing diabetic complications
- Albuminuria
- Acute kidney injury events
- Family history of DKD
- Poor controlled hypertension
- African, African-Caribbean or Asian or Hispanic family origin
- Chronic use of NSAIDs
- Untreated urinary outflow tract obstruction
- Smoking

National Institute for Health and Care Excellence Classification of CKD using GFR and ACR³ and recommended frequency of monitoring

GFR and ACR categories and risk of adverse outcomes			ACR categories (mg/mmol)			Increasing risk
			<3 Normal to mildly increased	3-30 Moderately increased	>30 Severely increased	
			A1	A2	A3	
GFR categories (ml/min/1.73 m ²)	≥90 Normal and high	G1	≤1	1	≥1	
	60-89 Mild reduction related to normal range for a young adult	G2	≤1	1	≥1	
	45-59 Mild-moderate reduction	G3a ¹	1	1	2	
	30-44 Moderate-severe reduction	G3b	≤2	2	≥2	
	15-29 Severe reduction	G4	2	2	3	
	<15 Kidney failure	G5	4	≥4	≥4	
				Increasing risk		

The recommended frequency of ACR and eGFR monitoring is documented within the boxes above e.g. for CKD G4A1, recommended frequency of monitoring is twice yearly. This should be used as a guide with other factors taken into account e.g. underlying cause of CKD, past eGFR and ACR patterns (nb CKD progression is not often linear), co-morbidities (especially heart failure), changes to treatment e.g. NSAIDs, renin angiotension aldosterone system antagonists, diuretics), intercurrent illness and whether the patient has chosen conservative management of CKD.

¹NICE recommend considering eGFRcystatinC for those with CKD G3aA1. See NICE Guideline [CG182](#) for further information