Clinical Practice Guideline on management of patients with diabetes and chronic kidney disease stage 3b or higher (eGFR <45 mL/min)

1. ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CKD</td>
<td>Chronic kidney disease</td>
</tr>
<tr>
<td>ACE-I</td>
<td>ACE inhibitor</td>
</tr>
<tr>
<td>ERA-EDTA</td>
<td>European Renal Association – European Dialysis and Transplant Association</td>
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<tr>
<td>ERBP</td>
<td>European Renal Best Practice</td>
</tr>
<tr>
<td>MD</td>
<td>Mean difference</td>
</tr>
<tr>
<td>OR</td>
<td>Odds ratio</td>
</tr>
<tr>
<td>RR</td>
<td>Relative risk</td>
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<tr>
<td>95% CI</td>
<td>95% Confidence interval</td>
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</table>

2. FOREWORD

Diabetes mellitus is becoming increasingly prevalent and is considered a rapidly growing concern for healthcare systems. Besides the cardiovascular complications, diabetes mellitus is associated with chronic kidney disease (CKD). CKD in patients with diabetes can be caused by true diabetic nephropathy, but can also be caused indirectly by diabetes, e.g. due to polyneuropathic bladder dysfunction, increased incidence of relapsing urinary tract infections or macrovascular angiopathy. However, many patients who develop CKD due to a cause other than diabetes will develop or may already have diabetes mellitus. Finally, many drugs that are used for management of CKDs, e.g. corticosteroids or calcineurin inhibitors, can cause diabetes.

Despite the strong interplay between diabetes and CKD, the management of patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) remains problematic. Many guidance-providing documents have been produced on the management of patients with diabetes to prevent or delay the progression to CKD, mostly defined as the presence of micro- and macro-albuminuria. However, none of these documents specifically deal with the management of patients with CKD stage 3b or higher (eGFR <45 mL/min). There is a paucity of well-designed, prospective studies in this population, as many studies exclude either patients with diabetes, or with CKD stage 3b or higher (eGFR <45 mL/min), or both. This limits the evidence base to these approaches.

In addition, due to some new developments in this area, the advisory board of ERBP decided that a guideline on the management of patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) was needed and timely:

1. The clear recognition of the importance of evidence-based approaches to patient care to enhance quality, improve safety and establish a clear and transparent framework for service development and healthcare provision.
2. The advent of new diagnostics and therapeutics in this area, highlighting the need for a valid, reliable and transparent process of evaluation to support key decisions.

In addition to a rigorous approach to methodology and evaluation, we were keen to ensure that the document focused on patient-important outcomes and had utility for clinicians involved in everyday practice.

We hope you will enjoy reading this guideline and that you will find it useful in your everyday management of patients with diabetes and CKD stage 3b or higher.

The guideline development group

3. COMPOSITION OF THE GUIDELINE DEVELOPMENT GROUP

After approval of the project concept by the ERBP advisory board, a working group convened in May 2011 who decided on the composition of the guideline development group, taking into account the clinical and research expertise of each proposed candidate. It was decided that, next to the current members of the guideline development group, additional external experts would be approached for their expertise in specific areas.

Guideline development group

See Supplementary data Appendix 1 for more complete biographies and declarations of interest.
4. CONFLICT OF INTEREST

4.1. Conflict of interest policy

We required all members of the guideline development group to complete a detailed declaration of interest statement including all current and future conflicts of interest as well as past conflicts of interest restricted to 2 years before joining the guideline development group. ERBP felt that excluding all
individuals with some degree of potential conflict of interest would prevent the assembly of a guideline development group. We therefore allowed members of the guideline development group to have past financial and/or intellectual conflicts of interest. We did not attach any consequences to the stated interests, but rather insisted on transparency. All members of the guideline development group were allowed to participate in all discussions and had equal weight in formulating the statements. All were allowed equal involvement in data extraction and writing the rationales.

4.2. Guideline development group declaration of interest
The declaration of interest forms are available from http://www.european-renal-best-practice.org/content/ERBP-Workgroup-Diabetes-0 and are updated on a regular basis. They can also be found in Supplementary data (Appendix 1).

5. PURPOSE AND SCOPE OF THIS GUIDELINE

5.1. Why was this guideline produced?
This clinical practice guideline was designed to facilitate informed decision-making on the management of adult individuals with diabetes mellitus and CKD stage 3b or higher (eGFR <45 mL/min). It was not intended to define a standard of care, and should not be construed as such. It should not be interpreted as a prescription for an exclusive course of management.

5.2. Who is this guideline for?
This guideline intends to support clinical decision making by any health care professional caring for patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min), i.e. for general practitioners, internists, surgeons and other physicians dealing with this specific patient population in both an outpatient and an in-hospital setting. The guideline also aims to inform about the development of standards of care by policy-makers.

5.3. What is this guideline about?
The intended scope of the guideline was determined at the first meeting held in Brussels in May 2011 with a steering group assembled for this purpose by the ERBP advisory board. This steering group defined a set of healthcare questions related to the management of patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) 3b–5. An electronic survey was taken among all members of European Renal Association-European Dialysis and Transplant Association to prioritize these questions.

5.3.1. Population. The guideline covers adults with diabetes mellitus and CKD stage 3b or higher (eGFR <45 mL/min), as defined by the recent KIDIGO classification [1]. The guideline does not cover interventions in patients with diabetes and CKD stages 1–2 to prevent or delay development of micro- or macro-albuminuria.

5.3.2. Conditions. The guideline specifically covers the management of patients with diabetes mellitus and CKD stage 3b or higher (eGFR <45 mL/min), with a focus on three major areas: (i) selection of renal replacement modality; (ii) management of glycaemic control; (iii) management and prevention of cardiovascular comorbidity.

5.3.3. Healthcare setting. This guideline targets the management of patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) in primary, secondary and tertiary healthcare settings.

5.3.4. Clinical management. The guideline intends to provide an evidence-based rationale for the day-to-day management of patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min), and to develop pathways of care by systematically compiling available evidence in this area. It provides an evidence-based rationale on why management of patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) should or should not be different from patients with diabetes but without CKD stage 3b or higher (eGFR <45 mL/min), or from patients with CKD stage 3b or higher (eGFR <45 mL/min) but without diabetes. In line with the mission statement of ERBP, the guideline document intends to inform all involved stakeholders and to stimulate shared decision-making [2].

6. METHODS FOR GUIDELINE DEVELOPMENT

6.1. Establishment of the guideline development group
As defined by our guideline development methodology [3], the ERBP advisory board installed a steering group, which, after selection of the topics, selected further members for the guideline development group. Members of the steering group and the guideline development group were selected based on their clinical and research expertise and their willingness to invest the necessary time and effort to perform the task according to the proposed deadlines and the agreed methodology. The guideline development group consisted of content experts, including individuals with expertise in endocrinology and diabetes, general internal medicine and clinical nephrology. In addition, experts in epidemiology and systematic review methodology were added to the guideline development group. The ERBP methods support team provided methodological input and practical assistance throughout the process.

6.2. Development of clinical questions
With the final guideline scope as point of departure, the guideline development group identified specific research questions for which a systematic review would be conducted. All questions addressed issues related to one of the following three areas:

1. Renal replacement modality selection in patients with diabetes with end-stage renal disease (CKD stage 5).
2. Glycaemic control in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min).
3. Management of cardiovascular risk in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min).

6.3. Development of review questions

The methods support team assisted in developing review questions, i.e. framing the clinical questions into a searchable format. This required detailed specification of the patient group (P), intervention (I), comparator (C) and outcomes (O) for intervention questions and the patient group, index tests, reference standard and target conditions for questions of diagnostic test accuracy [4]. For each question, the guideline development group agreed upon explicit review question criteria including study design features (see Appendices for detailed review questions and PICO tables).

6.4. Assessment of the relative importance of the outcomes

For each intervention question, the guideline development group compiled a list of outcomes, reflecting both benefits and harms of alternative management strategies. They ranked the outcomes as critical, highly important or moderately important according to the relative importance of that outcome in the decision-making process (Table 1).

6.5. Target population perspectives

An effort was made to capture the target population perspectives by adopting different strategies.

ERBP has a permanent patient representative on its advisory board. Although he was not included in the guideline development group or in the evidence review process, drafts of the guideline document were sent out for his review, and his comments were taken into account in revising and drafting the final document.

Table 1. Suggested outcomes and level of importance

<table>
<thead>
<tr>
<th>Critically important outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survival/mortality</td>
</tr>
<tr>
<td>Progression to end-stage kidney disease/Deterioration</td>
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<tr>
<td>of residual renal function</td>
</tr>
<tr>
<td>Hospital admissions: Highly important</td>
</tr>
<tr>
<td>QoL/patient satisfaction</td>
</tr>
<tr>
<td>Major morbid events</td>
</tr>
<tr>
<td>Myocardial infarction</td>
</tr>
<tr>
<td>Stroke</td>
</tr>
<tr>
<td>Amputation</td>
</tr>
<tr>
<td>Loss of vision</td>
</tr>
<tr>
<td>Highly important outcomes</td>
</tr>
<tr>
<td>Hypoglycaemia</td>
</tr>
<tr>
<td>Delayed wound healing</td>
</tr>
<tr>
<td>Infection</td>
</tr>
<tr>
<td>Visual disturbances</td>
</tr>
<tr>
<td>Pain</td>
</tr>
<tr>
<td>Functional status</td>
</tr>
<tr>
<td>Moderately important outcomes (surrogate outcomes)</td>
</tr>
<tr>
<td>Hyperglycaemia</td>
</tr>
<tr>
<td>Glycaemic control</td>
</tr>
<tr>
<td>Glycated haemoglobin</td>
</tr>
<tr>
<td>Point of care (measure)</td>
</tr>
<tr>
<td>Question-specific outcomes</td>
</tr>
<tr>
<td>As mentioned in the specific PICO questions</td>
</tr>
</tbody>
</table>

6.6. Searching for evidence

6.6.1. Sources. The ERBP methods support team searched The Cochrane Database of Systematic Reviews (May 2014), DARE (May 2014), CENTRAL (May 2014) and Medline (1946 to May, week 4, 2014) for all questions. The search strategies combined subject headings and text words for the patient population, index test and target condition for the diagnostic questions and subject headings and text words for the population and intervention for the intervention questions. The detailed search strategies are available in Appendix 3.

Reference lists from the included publications were screened to identify additional papers. The methods support team also searched guideline databases and organizations including the National Guideline Clearinghouse, Guidelines International Network, Guidelines Finder, Centre for Reviews and Dissemination, National Institute for Clinical Excellence and professional societies of nephrology and endocrinology for guidelines to screen the reference lists.

6.6.2. Selection. For diagnostic questions, we included all studies that compared any of the pre-defined clinical or biochemical tests with a golden standard reference test. For intervention questions, we included all studies in which one of the pre-defined interventions was evaluated in humans. We excluded case series that reported on benefit if the number of participants was \( \leq 5 \), but included even individual case reports if they reported an adverse event. No restriction was made based on language.

We used the Early Reference Organisation Software (EROS) (http://www.eros-systematic-review.org) to organize the initial step of screening and selection of papers. The title and abstract of all papers retrieved by the original search were made available to those responsible for screening through this system. For each question, a member of the ERBP methods support team and one member of the guideline development group dedicated to this question independently screened all titles and abstracts and discarded the clearly irrelevant ones and those that did not meet the inclusion criteria. Any discrepancies at this stage were resolved by consensus.

In a second round, full texts of potentially relevant studies were retrieved and independently examined for eligibility and final inclusion in the data extraction step. Any discrepancies were resolved by consensus. If no consensus could be reached, the disagreement was settled by group arbitration.

The flow of the paper selection is presented for each question in Appendix 5.

6.6.3. Data extraction and critical appraisal of individual studies. For each included study, we collected relevant information on design, conduct and relevant results through a tailor-made online software system. For each question, two reviewers independently extracted all data. We produced tables displaying the data extraction of both reviewers. Any discrepancies were resolved by consensus, and if no consensus could be reached, disagreements were resolved by a third independent referee. From these data extraction tables, we produced merged consensus evidence tables for informing the recommendations. The evidence tables are available in Appendix 6.
Risk of bias of the included studies was evaluated using validated checklists, as recommended by the Cochrane Collaboration. These were AMSTAR for Systematic Reviews [5], the Cochrane Risk of Bias tool for randomized controlled trials (RCTs) [6], the Newcastle Ottawa scale for cohort and case–control studies [7] and QUADAS for diagnostic test accuracy studies [8]. Data were compiled centrally by the ERBP methods support team.

6.6.4. Evidence profiles. For research questions regarding therapeutic interventions, the methods support team constructed evidence profiles using the ‘Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox’ developed by the international GRADE working group (http://www.gradeworkinggroup.org/). The evidence profiles include details of the quality assessment as well as summary—pooled or unpooled—outcome data, an absolute measure of intervention effect when appropriate, and the summary of quality of evidence for each outcome. Evidence profiles were reviewed and approved with the rest of the guideline development group. Evidence profiles were constructed only for research questions addressed by at least two RCTs. If the body of evidence for a particular comparison of interest consisted of only one RCT or of solely observational data, the summary tables provided the final level of synthesis.

6.7. Rating the quality of the evidence for each outcome across studies

The guideline development group rated the overall quality of the evidence for each intervention separately addressing each outcome (see Table 3). In accordance with GRADE, the guideline development group initially categorized the quality of the evidence for each outcome as high if it originated predominantly from RCTs and as low if it originated from observational studies. We subsequently downgraded the quality of the evidence one or two levels if results from individual studies were at a high or very high risk of bias, there were serious inconsistencies in the results across studies, the evidence was indirect, the data were sparse or imprecise or publication bias was suspected.

Table 2. Method of rating the quality of the evidence. Adapted from Balshem et al. [222]

<table>
<thead>
<tr>
<th>Step 1: Starting grade according to study design</th>
<th>Step 2: Lower if</th>
<th>Step 3: Higher if</th>
<th>Step 4: Determine final grade for quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randomized trials = high</td>
<td>Risk of bias</td>
<td>Large effect</td>
<td>High (four plus: ⊕⊕⊕⊕)</td>
</tr>
<tr>
<td>Observational studies = low</td>
<td>— 1 Serious</td>
<td>+ 1 Large</td>
<td>Moderate (three plus: ⊕⊕⊕)</td>
</tr>
<tr>
<td></td>
<td>— 2 Very serious</td>
<td>+ 2 Very large</td>
<td>Low (two plus: ⊕⊕)</td>
</tr>
<tr>
<td></td>
<td>Inconsistency</td>
<td>Dose–response</td>
<td>Very Low (one plus: ⊕⊕)</td>
</tr>
<tr>
<td></td>
<td>— 1 Serious</td>
<td>+ 1 Evidence of a gradient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— 2 Very serious</td>
<td>All plausible confounding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indirectness</td>
<td>+ 1 Would reduce a demonstrated effect</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— 1 Serious</td>
<td>+ 1 Would suggest a spurious effect</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— 2 Very serious</td>
<td>when results show no effect</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imprecision</td>
<td>— 1 Serious</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— 2 Very serious</td>
<td>— 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Publication Bias</td>
<td>— 1 Likely</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— 2 Very likely</td>
<td>— 2</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Grade for the overall quality of evidence. Adapted from Guyatt et al. [223]

<table>
<thead>
<tr>
<th>Grade Quality Level</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A High</td>
<td>We are confident that the true effects lie close to those of the estimates of the effect.</td>
</tr>
<tr>
<td>B Moderate</td>
<td>The true effects are likely to be close to the estimates of the effects, but there is a possibility that they are substantially different.</td>
</tr>
<tr>
<td>C Low</td>
<td>The true effects might be substantially different from the estimates of effects.</td>
</tr>
<tr>
<td>D Very low</td>
<td>The estimates are very uncertain and will often be far from the truth.</td>
</tr>
</tbody>
</table>

The quality of evidence arising from observational studies was upgraded if effect sizes were large, there was evidence of a dose–response gradient, or all plausible confounding would either reduce a demonstrated effect or suggest a spurious effect when results showed no effect (Table 2). Uncontrolled case series and case reports automatically received downgrading from a ‘low’ to ‘very low’ level of evidence for risk of bias, so that no other reasons for downgrading were marked.

6.8. Formulating and grading statements

6.8.1. Statements. After the evidence tables and profiles had been prepared, revised and approved, the guideline development group formulated and graded the statements during two full-day plenary meetings.

Recommendations can be for or against a certain strategy. The guideline development group drafted the statements based on their interpretation of the available evidence. Individual statements were made and discussed in an attempt to reach group consensus. If we could not reach consensus, we held a formal open vote by show of hands. An arbitrary 80% had to cast a positive vote for a statement to be accepted. Voting results and reasons for disagreement were specified in the rationale where applicable. In accordance to GRADE [9], we classified the strength of the statements as strong (coded 1) or weak (coded 2) (Table 4, Figure 1).
Judgements around four key factors determined the strength of a recommendation: the balance between desirable and undesirable consequences of alternative therapeutic or diagnostic strategies, the quality of the evidence and the variability in values and preferences. We did not conduct formal decision or cost analysis.

6.8.2. Ungraded statements. We decided to use an additional category of ungraded statements for areas where formal evidence was not sought and statements were based on common sense, or expert experience alone. The ungraded statements were generally written as simple declarative statements but were not intended to be stronger than level 1 or 2 recommendations.

6.8.3. Optimizing implementation. Recommendations often fail to reach implementation in clinical practice partly because of their wording [10, 11]. Care was therefore taken to produce the evidence in clear, unambiguous wordings. Preferentially, data were presented either as flowcharts with decision points or as tables.

We also provided additional advice for clinical practice. This advice is not graded, elaborates on one or more statements and is intended only to facilitate practical implementation.

6.9. Writing the rationale

We collated recommendations and ungraded statements for each clinical question in separate chapters structured according to a specific format. Each question resulted in one or more specific boxed statements. All statements were accompanied by their GRADE classification as levels 1 or 2 (strength of recommendations) and A, B, C or D (quality of the supporting evidence) (Table 4).

These statements are followed by advice for clinical practice where relevant and the rationale of the statement. The rationale contains a brief section on ‘Why this question?’ with relevant background and justification of the topic, followed by a short narrative review of the evidence in ‘What did we find?’ and finally a justification of how the evidence was translated into the recommendations made in ‘How did we translate the evidence into the statement?’

When areas of uncertainty were identified, the guideline development group considered making suggestions for future research based on the importance to patients or the population, and on ethical and technical feasibility.

6.10. Internal and external review

6.10.1. Internal review. A first draft of the guideline was sent to internal reviewers from the ERA-EDTA council and the ERBP advisory board. Internal reviewers were asked to comment on the statements and the rationale within free textfields. All these comments and suggestions were discussed during an ERBP advisory board meeting, during a meeting of the ERBP methods support team, and during an additional teleconference meeting of the guideline development group. For each comment or suggestion, the guideline development group

Table 4. Implications of strong and weak recommendations for stakeholders. Adapted from Guyatt et al. [224]

<table>
<thead>
<tr>
<th>Grade</th>
<th>Implications</th>
<th>Patients</th>
<th>Clinicians</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Strong, 'We recommend'</td>
<td>Most people in your situation would want the recommended course of action, only a small proportion would not.</td>
<td>Most patients should receive the recommended course of action.</td>
<td>The recommendation can be adopted as policy in most situations.</td>
<td></td>
</tr>
<tr>
<td>2: Weak, 'We suggest'</td>
<td>Most people in your situation would want the recommended course of action, but many would not.</td>
<td>You should recognize that different choices will be appropriate for different patients. You must help each patient to arrive at a management decision consistent with her or his values and preferences.</td>
<td>Policy-making will require substantial debate and involvement of many stakeholders.</td>
<td></td>
</tr>
</tbody>
</table>

The additional category ‘ungraded’ was used, typically, to provide guidance based on common sense rather than on a systematic literature search. Where applicable, these statements were provided as ‘advice for clinical practice’. Typical examples include recommendations regarding monitoring intervals, counselling and referral to other clinical specialists. The ungraded recommendations are generally written as simple declarative statements, but are not meant to be interpreted as being stronger recommendations than level 1 or 2 recommendations.

![FIGURE 1: Grade system for grading recommendations. Adapted from Guyatt et al. [9].](http://dx.doi.org/10.1016/j.ajkd.2015.06.002)
evaluated whether the statement needed to be adapted, again taking into account the balance between desirable and undesirable consequences of the alternative management strategies, the quality of the evidence, and the variability in values and preferences.

6.10.2. External review. The guideline was sent to the Endocrine Society of Australia (ESA), the European Society of Endocrinology, Kidney Health Australia–Caring for Australasians with Renal Impairment (KHA-CARI) and the American Society of Nephrology (ASN), with the request to have the guideline evaluated by two of their members.

In addition, all members of the ERA-EDTA received an online questionnaire in Survey Monkey format to evaluate the guideline using the AGREE-II framework. In addition, a free text field was provided to allow for additional comments (see Appendix 6).

All comments and suggestions were discussed with the guideline development group by e-mail, as well as during a final meeting of the co-chairs of the guideline development group, the methods support team and the chair of ERBP.

6.11. Timeline and procedure for updating the guideline

The guideline will be updated every 5 years or earlier following publication of new evidence that may require additional statements or changes to existing statements.

At least every 5 years, the ERBP methods support team will update its literature searches. Relevant studies will be identified and their data extracted using the same procedure as for the initial guideline. During a one-day meeting, the guideline development group will decide whether or not the original statements require updating. An updated version of the guideline will be published online describing the changes made.

During the 5-year interval, the guideline development group co-chairs will notify the ERBP chair of new information that may justify changes to the existing guideline. If the chair decides an update is needed, an updated version of the guideline will be produced using the same procedures as for the initial guideline.

6.12. Funding

ERBP sponsored the entire production of this guideline, according to the statutes of ERA-EDTA and the bylaws of ERBP [3].

Activities of ERBP and its methods support team are supervised by an advisory board [3] (see www.european-renal-best-practice.org for details and declaration of interests). ERBP is an independent part of ERA-EDTA. The council of ERA-EDTA approves and provides the annual budget based on a proposition made by the ERBP chair. ERA-EDTA receives money and is partly funded by industrial partners, but its council is not involved with and does not interfere with question development or any other part of the guideline development process. The guideline development group did not receive any funds directly from industry to produce this guideline.

7. CHAPTER 1: ISSUES RELATED TO RENAL REplacement MODALITY SELECTION IN PATIENTS WITH DIABETES AND END-STAGE RENAL DISEASE

Chapter 1.1. Should patients with diabetes and CKD stage 5 start with peritoneal dialysis or haemodialysis as a first modality?

Statements

1.1.1 We recommend giving priority to the patient’s general status and preference in selecting renal replacement therapy as there is an absence of evidence of superiority of one modality over another in patients with diabetes and CKD stage 5 (1C).

1.1.2 We recommend providing patients with unbiased information about the different available treatment options (1A).

1.1.3 In patients opting to start haemodialysis (HD), we suggest preferring high flux over low flux when this is available (2C).

1.1.4 We suggest diabetes has no influence on the choice between HD or haemodiafiltration (HDF) (2B).

Advice for clinical practice

Make sure that all the different renal replacement therapy modalities (peritoneal dialysis (PD), in-centre HD, satellite HD, home HD, nocturnal dialysis, different modalities of transplantation) can be made equally available for all patients is indispensable to allow free modality choice.

Rationale

- Why this question?

It is unclear whether, in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min), the modality of renal replacement therapy (different modalities of HD or PD, or transplantation etc.) that is selected as first-choice treatment may have an impact on major outcomes, metabolic profile, diabetes complications and technique survival of the replacement therapy.

- What did we find?

To answer this question, we refer to the systematic literature review specifically performed for this guideline [12]. This systematic review included 25 from the initial 426 records retrieved through database searching. All studies but one [13] were observational. None included only patients with diabetes; the percentage of patients with diabetes ranged from 9% to 61%. The total number of patients with diabetes included was 828 573, of which 721 783 were on HD and 106 790 on PD. Not enough treatment details were available to allow reliable analysis of the benefit of subcategories of HD or PD (e.g. HD versus HDF or manual versus automated PD). The overall study quality assessed by the Newcastle-Ottawa Scale was moderate to high.

Because of their observational design, none of the included studies was free from selection bias. There was
significant heterogeneity in the length of follow-up among studies (from 1 to 8 years) which may hamper the generalizability of results.

None of the reviewed studies provided data on quality of life (QoL), patient satisfaction, major and minor morbid events, hospital admissions, deterioration of residual renal function, functional status, glycemia control, access to transplantation or survival of the technique. Twenty-four cohort studies analysed the risk of death. Only one cohort study considered the risk of infectious complications.

In intention-to-treat analyses (i.e. patients are assigned to their initial treatment and not to the treatment eventually received), most studies found a survival benefit for PD over HD in the beginning of treatment, that disappeared with length of time on treatment (Supplementary data extraction tables). The duration of this advantage varied from 6 months to 3 years after the start of dialysis, depending on the underlying comorbidities (congestive heart failure, coronary heart disease), gender and age of the observed cohort, region and time-period.

In ‘as treated’ analyses (i.e. patients are considered at risk as long they are treated in the modality), heterogeneity was even more expressed, with some studies reporting PD was associated with improved survival in all patients [14], or only in patients under 60 years of age during the first 2 years [15], patients under 65 years [16] or during the first year [17]. In patients aged over 44, Yeates et al. showed a higher risk of death in patients with diabetes on PD [18]. Stack et al. [19] reported the adjusted mortality to be higher for PD patients with congestive heart failure who remained on this therapy during the follow-up and for patients who switched compared with those who remained on HD. In the subgroup without congestive heart failure, the mortality was similar for patients who remained either on HD or PD but was higher for those who switched. This study is, however, biased by the exclusion of patients who died in the first 90 days.

Only one small cohort study reported on infectious complications, with higher infection rates (hospitalization or access-related infections) being observed in PD patients with diabetes (1.28 versus 0.84/year, P <0.004) but this difference lost its statistical significance after adjustment for albumin, age, race and gender (RR 1.13; 95% CI 0.76–1.67) [20].

A systematic review (26 studies) on the impact of dialysis modality (centre HD and PD) on QoL [21] was retrieved. The authors concluded that there was no significant difference in QoL between HD and PD patients. PD patients tend to rate their QoL higher than HD patients. Worsening of physical component of QoL was more marked in PD patients.

Another systematic review (52 articles) on the impact of RRT modality (HD, PD and TX) on QoL as assessed by the SF-36 score [22] concluded that scores of HD compared with PD patients were not statistically different. Results are similar when restricting the analyses to articles that reported the per cent of patients with diabetes. A third systematic review (27 articles) based on utility measures to assess preference-based QoL (HD, PD and TX) [23] concluded that there was no statistically significant difference in utilities between HD and PD patients. Mean QoL tended to be higher among PD patients. A fourth systematic review (190 articles) based on utility-based QoL (HD, PD, TX, CKD, conservative treatment) [24] concluded that there was no statistically significant difference in utilities between HD and PD patients. Mean utility estimate tended to be higher among PD patients.

We found one meta-analysis on the impact of haemodialysis versus HDF, showing no interaction for presence of diabetes [25].

• How did we translate the evidence into the statement? Which considerations were taken into account (GRADE)?

We recommend giving priority to the patient’s condition and preference in selecting renal replacement therapy as there is an absence of evidence of superiority of one modality over another in patients with diabetes and CKD stage 5 (1C).

We recommend providing patients with unbiased information about the different available treatment options (1A).

In view of the numerous methodological pitfalls in the various observational studies, no firm conclusion can be drawn. If anything, the observed differences in survival between the different modalities seem to be small, suggesting that they all can be considered ‘equally adequate treatments’ in general terms, when applied in the current indications and with the current technology.

In view of this, the guideline development group judges that patient preference should be the driving factor for renal replacement modality choice. Therefore, the guideline group judges that availability of all of the different renal replacement therapy options and good, well-balanced education on the different modalities, for example the Yorkshire Dialysis Decision Aid (YODDA) (see link on website www.european-renal-best-practice.org) are essential first steps.

In patients opting to start HD, we suggest preferring high flux over low flux when this is available (2C).

We suggest diabetes has no influence on the choice between HD or HDF (2B).

In patients opting for HD, it is suggested that high-flux dialysis is preferred when this is available and affordable, consistent with the ERBP recommendation on the use of high-flux versus low-flux membranes [26]. In a recent meta-analysis of HDF versus HD, no interaction for diabetes and HDF versus HD was observed [25]. Consequently, the choice for HD versus HDF should not be influenced by the diabetes status of the patient.

What do the other guidelines say?

We did not find other guidelines providing guidance on this area.

Suggestions for future research

1. Establish and validate patient decision aids on modality selection; test whether use of these decision aids results in improved outcomes, QoL and patient satisfaction.
2. Analyse outcomes on PD versus HD in different subgroups, such as elderly patients with diabetes, while taking into account differences in practices in different centres and countries (e.g. impact of assisted care).
3. Development and validation of decision-making tools for the timely transfer to HD/PD after PD/HD start.
4. Develop and validate statistical models that can take into account modality transfers and thus allow the exploration of different patient trajectories rather than HD versus PD.

Chapter 1.2. Should patients with diabetes and CKD stage 5 start dialysis earlier, i.e. before becoming symptomatic, than patients without diabetes?

Statements
1.2.1 We recommend initiating dialysis in patients with diabetes on the same criteria as in patients without diabetes (1A).

Advice for clinical practice
1. Distinguish complaints due to long-standing diabetes (polyneuropathy, gastroparesis versus nausea on uraemia etc.) from uraemic complaints might be cumbersome in clinical practice.
2. In patients opting for HD, take into account and discuss with the patient the following factors to determine the decision on and optimal timing of vascular access creation:
   (a) speed of deterioration of renal function
   (b) projected probability that a functioning vascular access will be achieved
   (c) projected life expectancy.

Rationale
• Why this question?
  We aimed to clarify whether the starting of dialysis without clinical symptoms of uraemia at a predefined fixed point of clearance may produce favourable outcomes in patients with diabetes when compared with waiting to start renal replacement until patients do have uraemic complaints (as is recommended for patients without diabetes [27, 28]).

• What did we find?
  We found 12 papers reporting 11 studies on the association between some form of early versus late start of dialysis and survival/mortality on dialysis. One study was an RCT, three studies were prospective cohorts and the remaining studies were retrospective cohorts. The RCT was the IDEAL study by Cooper et al. [29], which was performed in 828 patients in Australia and New Zealand. Although initially patients randomized to late start were to start dialysis between 5 and 7 mL/min/1.73 m² creatinine clearance as estimated by Cockcroft and Gault (eGFRCG), and the early start group was supposed to start between 10 and 14 mL/min/1.73 m²; in reality, eGFRCG at start of dialysis was 9.8 and 12.0 mL/min/1.73 m² in the late and early start group, respectively. So, the difference in eGFRCG at start of dialysis was only 2.2 mL/min/1.73 m². This difference did not appear to result in a change in survival between early and late start. However, patients in the late start group started on average 6 months later than patients in the early start group. The IDEAL study provided a subgroup analysis for the 34% of patients with diabetes, and in those patients there was also no difference in survival between early and late start of dialysis in patients with diabetes.

There were three prospective studies. Contreras-Velazquez et al. [30] performed a study in 98 patients with the aim to identify peritoneal anatomical changes in incident PD patients, their role in peritoneal permeability, technique failure, and mortality on PD. There was no data on the subgroup of 24% PD patients with diabetes. Tang et al. [31] performed a prospective cohort study in 233 Asian patients. The comparison was between patients who accepted PD and were immediately started and patients who declined PD and were followed up on the low clearance clinic. Again, there were no separate data provided on the subgroup of patients with diabetes.

The remaining studies were all retrospective cohort studies. Chandna et al. [32] compared survival in patients whose start of dialysis was planned (n = 163) versus survival in patients in whom start of dialysis was unplanned (n = 129). A comparison in survival between patients with (n = 59) versus without diabetes (n = 229) was presented, showing no difference between the two groups, but separate results for patients with diabetes were not presented. In only 25% of the patients with diabetes was dialysis unplanned versus 49% in patients without diabetes, indicating that the comparison of planned versus unplanned dialysis is perhaps different in patients with versus without diabetes. Finally, probably planned versus unplanned start of dialysis cannot be considered the same as early versus late start of dialysis.

Coronel et al. [33] compared survival in 100 patients with diabetes that started PD either below or equal and higher to 7.7 mL/min/1.73 m², finding that starting early (i.e. ≥7.7 mL/min/1.73 m²) was significantly associated with better survival at 3 years (61% versus 39%). However, this is an observational retrospective study; and patients who started at an eGFR below 7.7 mL/min/1.73 m² were not comparable with patients who start at higher levels. Kazmi et al. [34] studied the effect of comorbidity on the association between eGFR at start of dialysis and survival on dialysis in more than 300 000 people in the USA. They found that the higher levels of eGFR at the start of dialysis were associated with significantly worse survival on dialysis, even after adjustment for comorbidity. However, there was no formal subgroup analysis in patients with diabetes alone. Lassalle et al. [35] analysed more than 11 000 patients in the French REIN registry, looking at the association between eGFR at start of dialysis and survival on dialysis with extensive adjusting for confounders. Results showed that, even after adjustment, higher eGFR levels at the start of dialysis were associated with poor survival on dialysis. Traynor et al. [36] studied the effect of lead-time bias in 235 European patients by calculating when these patients reached eGFR = 20 mL/min/1.73 m² and using this point as the start of follow-up. They
demonstrated that lead-time bias can partly explain the effect between eGFR at the start of dialysis and survival on dialysis. Higher levels of eGFR at the start of dialysis were associated with poor survival on dialysis, but there was no formal subgroup analysis in patients with diabetes. Wright et al. [37] also studied the effect of early and late start of dialysis on survival on dialysis in almost 900,000 patients in the USA. They also showed that higher levels of eGFR at the start of dialysis are associated with poor survival on dialysis in the subgroup analysis in patients with diabetes, they showed a similar result. Beddhu et al. [38] also investigated timing of start of dialysis, modelled as renal function at the start of dialysis in a continuous fashion, in incident haemodialysis and PD patients.

They found that every increase in eGFR (MDRD) at baseline with 5 mL/min led to a 14% increased risk of dying on dialysis [HR = 1.15 (1.06–1.14)]. Hwang et al. [39] demonstrated that there was a dose–response relationship between the level of eGFR at the start of dialysis and risk of mortality on dialysis, even after adjustment for potential confounders [Q1 as reference: Q2: HRAdj = 1.18 (95% CI 1.01–1.37), Q3: HRAdj = 1.21 (95% CI 1.04–1.41), Q4: HRAdj = 1.66 (95% CI 1.43–1.93), and Q5: HRAdj = 2.44 (95% CI 2.11–2.81). Clark et al. [40] found that 8441 patients in the CORR cohort who started dialysis early [eGFR (MDRD) >10.5 mL/min] had 18% more risk of dying on dialysis [HR = 1.18 (95% CI 1.13–1.23)] compared with late start of dialysis [eGFR (MDRD) ≤10.5 mL/min] in 17,469 incident HD patients. Jain et al. [41] did not detect a survival difference between patients starting dialysis early (n = 2994) [eGFR (MDRD) >10.5 mL/min] [HR = 1.08 (95% CI 0.96–1.23)] mid-start of dialysis (n = 2670) [eGFR (MDRD) 7.5–10.5] [HR = 0.96 (95% CI 0.86–1.09)] versus late [eGFR (MDRD) <7.5 mL/min].

For all these studies, it is likely that the remaining confounding induced by the use of estimated rather than measured GFR explains the worse outcome of start at higher eGFR. Indeed, eGFR is based on creatinine, which itself is negatively impacted by malnutrition and poor food intake, and is diluted by fluid overload. Both of these conditions will result in an overestimation of true GFR by eGFR, and also result in worse outcomes.

- **How did we translate the evidence into the statement? Which considerations were taken into account (GRADE)?**

Based on one RCT, there appears to be no evidence to support the hypothesis that in patients with diabetes, start of dialysis based on pre-defined levels of eGFR before they become symptomatic versus when they become symptomatic is of any benefit in terms of mortality or QoL. As such, the same recommendations as made previously by ERBP [27] for the general CKD 5 population can be maintained for CKD 5 patients with diabetes.

In patients with diabetes, it might be cumbersome to distinguish whether polyneuropathy, nausea, concentration disturbances or sleepiness are to be attributed as ‘uraemic’ or as ‘diabetes-related’ symptoms. To the knowledge of the guideline development group, there are no strict and clear criteria that can be forwarded to assist in making this distinction. Therefore, it can be that, in reality, patients with diabetes start at somewhat higher eGFR levels compared with patients without diabetes. Although this was already mentioned in the original guidance published by ERBP [27] after publication of the IDEAL trial (Guideline 1.3: High-risk patients e.g. with diabetes and those whose renal function is deteriorating more rapidly than eGFR 4 mL/min/year require particularly close supervision. Where close supervision is not feasible and in patients whose uraemic symptoms may be difficult to detect, a planned start to dialysis while still asymptomatic may be preferred), the reassessment in the current guidance production process makes it clear that there is no reason to start patients with diabetes at higher levels of eGFR just because they have diabetes, rather only (as for those without diabetes) because they are symptomatic. The new statement abolishes eventual ambiguity arising from the original statements, and should be seen as an addition to them.

The guideline development group also wants to stress that in the IDEAL trial, all patients had been followed by a nephrology centre for a substantial period of time, and most had a functioning access in place at start of renal replacement therapy. Therefore, discussion of the different renal replacement modalities and selection of a preferred dialysis modality in a shared decision-making process should be started timely.

As creation of vascular access might be problematic, and as maturation failure might be prevalent in patients with diabetes, the guideline group judges that it is advisable to discuss in a timely manner, in patients opting for HD, the creation of a vascular access. In this discussion, the speed of deterioration of renal function should be taken into account, as not all patients might be progressive. In addition, the general condition of the patient, and the likelihood of death before ESRD rather than evolution to ESRD should be evaluated.

**What do the other guidelines say?**

We did not find other guidelines providing guidance on this topic.

**Suggestions for future research**

1. Develop and validate clinical/biochemical scores to distinguish uraemic and diabetes related complaints.

**Chapter 1.3. In patients with diabetes and CKD stage 5, should a native fistula, graft or tunnelled catheter be preferred as initial access?**

**Statements**

1.3.1 We recommend that reasonable effort be made to avoid tunnelled catheters as primary access in patients with diabetes starting HD as renal replacement therapy (1G).

1.3.2 We recommend that the advantages, disadvantages and risks of each type of access be discussed with the patient.
Advice for clinical practice

- When deciding whether or not to create a native vascular access, the following points should be considered:
  - expected life expectancy of the patient
  - expected QoL of the patient
  - probability of success of native access creation, as predicted based on ultrasound and Doppler results (Figure 2).

Rationale

- Why this question?
  From observational trials, it is clear that HD patients with a native vascular access have a better outcome when compared with those starting with a catheter. However, ‘not having a native fistula’ can be a marker of severity of disease, especially in patients who also have diabetes. In addition, in patients with diabetes, creation of a vascular access, and especially at the more distal parts of the arm, can be cumbersome in view of the presence of vascular disease. This might result in repetitive attempts to create native vascular access without clinical success.

  It is important to clarify the most advisable strategy of vascular access planning (type of vascular access, central venous catheter (CVC) or arteriovenous fistula (AVF) or graft (AVG) and position) in this patient group, and define whether, and to what extent, it should be different from patients without diabetes.

- What did we find?
  The full results of this systematic review are published in a separate document [42]. In this systematic review, we identified 262 records, of which 213 were excluded based on title and abstract. As a result, 49 full-text articles were accessed and evaluated, resulting in the further exclusion of 36 articles. Finally, 13 studies were included in the data extraction table: 2 prospective cohort studies, but which dated from an older era [43, 44], 10 retrospective cohort studies [45–53] and 1 case–control study [54]. We did not retrieve any randomized clinical trial.

  We also included one systematic review on the topic of vascular access in the general dialysis population [55], starting from the hypothesis that if any difference at all exists in the population without diabetes, it was most likely that success of vascular access will be worse in patients with diabetes. This systematic review identified 3965 citations, of which 67 (62 cohort studies comprising 586 337 participants) were data extracted. In a random-effects meta-analysis, compared with persons with fistulas, those individuals using catheters had higher risks for all-cause mortality (risk ratio = 1.53, 95% CI 1.41–1.67), fatal infections (2.12, 1.79–2.52) and cardiovascular events (1.38, 1.24–1.54). Similarly, compared with persons with grafts, those individuals using catheters had higher odds of mortality (1.38, 1.25–1.52), fatal infections (1.49, 1.15–1.93), and cardiovascular events (1.26, 1.11–1.43). Compared with persons with fistulas, those individuals with grafts had increased all-cause mortality (1.18, 1.09–1.27) and fatal infection (1.36, 1.17–1.58), but no higher risk for cardiovascular events (1.07, 0.95–1.21). The authors note that the risk for selection bias was high in all studies.

Patient survival

In a retrospective cohort study of incident, >65-year-old HD patients (total n = 764 200 patients with diabetes), Chan et al. [45] reported a similar mortality rate and vascular access patency among patients with AVF versus AVG. Dhingra et al.
[47] reported in a retrospective cohort study of incident and prevalent HD patients (total n = 5189 patients, 31% with diabetes) that all-cause and CV mortality were higher in CVC versus AVF, and all-cause and infection mortality were higher in AVG versus AVF. In a prospective single-centre cohort study including incident and prevalent HD patients (total n = 21863 with diabetes), Saxena et al. [44] reported a lower rate of vascular access-related sepsis among patients with AVF compared with those with AVG or dialysis catheter; patients with femoral catheters presented a higher sepsis-related mortality in comparison with those with AVF and AVG.

**Survival of the access**

In a retrospective single-centre cohort study including ESRD patients who underwent proximal AVF creation (total n = 29368 with diabetes), Murphy et al. [51] reported apparently similar results for age and better results in males versus females, but no statistical significance was reported. Field et al. [48] reported a better survival of proximal versus distal AVF in patients with diabetes in a retrospective single-centre cohort study including 289 incident HD patients (103 with diabetes, 36%), but also here no statistical significance was reported. In a prospective single-centre cohort study including 197 incident HD patients (43 with diabetes, 22%) who underwent AVF creation by nephrologists [43], similar cumulative patency rates between distal versus proximal AVF were observed. Konner et al. [50] reported in their retrospective single-centre cohort study [total n = 247 patients, 78 with diabetes (22.5%)] a higher mortality and lower primary patency rate in patients with diabetes; no separate data were provided amongst patients with diabetes for distal versus proximal AVF. Also, a lower primary patency rate in non-perforating proximal AVF versus perforating proximal AVF and distal AVF was reported; the cumulative patency rates among the three study groups was similar, but thrombosis rate was lower among those with a proximal perforating AVF. This study has a high risk of selection bias, and all procedures were performed by one expert. Hammers et al. [49] reported in a retrospective single-centre cohort study (total n = 127, 52 with diabetes) that patients with versus without diabetes had a lower prevalence of cephalic arch stenosis, but the interpretation of these data is cumbersome, as there is a high risk of indication bias. Diehm et al. [53] found lower patency rates in a retrospective single-centre cohort study (total n = 244, 62 with diabetes) in patients with diabetes, and this using a mixture of different AV fistula types. Yeager et al. [54] report the risk factors associated with finger gangrene after placement of an AV fistula in a case-control single-centre study [total n = 222 patients, 121 with diabetes (54%)]: diabetes, peripheral and coronary artery disease (CAD) and age under 55 years at the start of dialysis.

While awaiting a formal systematic literature review and guidance from the update of the EBPG guideline on vascular access from 2007, we used recent updates of the CARI guideline [56] to support technical details of vascular access creation.

**How did we translate the evidence into the statement?**

We recommend reasonable effort be made to avoid tunnelled catheters as primary access in patients with diabetes starting HD as renal replacement therapy (1C).

There has been a general awareness in the nephrology community of the too high rates of prevalent dialysis patients on catheters. Over the last years, there has been a general consensus that efforts should be made to reduce these high rates as, according to various large observational studies [55], there is a clear link between catheter use and higher mortality and infection rates. Based on this consensus, several initiatives, e.g. ‘the fistula first’ initiative, have been launched, and some countries even linked reimbursement to vascular access type. Whereas these initiatives were successful in increasing the percentage of prevalent patients dialysing with a native fistula, it became clear that this growth was lower than expected and came at the expense of enormous efforts and costs for the society and suffering for the patient [57–59]. The major underlying explanation appears to be that there is selection bias in the observational trials because of the association between (cardiovascular) status and the propensity to having a functioning fistula.

We recommend that the advantages, disadvantages and risks of each type of access be discussed with the patient.

Although the evidence is scanty, creation of vascular access is more cumbersome and results more often in non-maturation in patients with versus without diabetes, and this particularly in women and the elderly. Factors predicting non-maturation in the general dialysis population, such as a diameter of the feeding artery <2 mm and/or of the draining vein <2.5 mm, or absence of flow increase with fist exercise, should certainly raise concern as to the probability that a functioning access can be created in such a patient [56]. In addition, life expectancy in some patients is low, and protracted and persisting efforts to create a vascular access might cause a substantial decrease in QoL, without adding any substantial benefit (Figure 2).

**What do the other guidelines say?**

No guideline provides specific recommendations for patients with diabetes. KDOQI, CARI, CSN and UK-RA all recommend using a native fistula as preferred access, when feasible. Three of them recommend trying to place a graft rather than a tunnelled catheter in case a native fistula is deemed impossible. In their respective discussions, they all highlight that the creation of a native vascular access might be more problematic in patients with versus without diabetes.
Suggestions for future research

1. Detailed observational studies to associate practices concerning vascular access creation with outcomes, and this using advanced statistical techniques to adjust for comorbidities such as age, gender, diabetes status, cardiovascular disease and for surgical technique.

2. Based on the above, RCTs should be designed to explore potential hypotheses.

Chapter 1.4 Is there a benefit to undergoing renal transplantation for patients with diabetes and CKD stage 5?

### 1.4.1 We recommend providing education on the different options of transplantation and their expected outcomes for patients with diabetes and CKD stage 4 or 5 who are deemed suitable for transplantation (Table 5) (1D).

#### Statements only for patients with type 1 diabetes and CKD stage 5

1.4.2 We suggest living donation kidney transplantation or simultaneous pancreas kidney transplantation to improve survival of suitable patients (2C).

1.4.3 We suggest against islet transplantation after kidney transplantation with the aim to improve survival (2C).

1.4.4 We suggest pancreas grafting to improve survival after kidney transplantation (2C).

#### Statements only for patients with type 2 diabetes and CKD stage 5

1.4.5 We recommend against pancreas or simultaneous kidney pancreas transplantation (1D).

1.4.6 We recommend diabetes in itself should not be considered a contraindication to kidney transplantation in patients who otherwise comply with inclusion and exclusion criteria for transplantation (1C).

Advice for clinical practice

- Successful simultaneous pancreas–kidney transplantation improves QoL, neuropathy, glycaemic control and diabetic retinopathy in type 1 diabetes.

- Perioperative comorbidity of simultaneous pancreas kidney transplantation can be substantial.

- We refer to the ERBP guideline [60] on kidney transplant donor and recipient evaluation and peri-operative management for assessing whether or not a patient is deemed suitable for transplantation.

Rationale

- Why this question?
  
The guideline development group wants to provide a recommendation on whether transplantation is a viable option in patients with diabetes and whether some subgroups or some types of transplantation (cadaveric kidney, living donor kidney, simultaneous pancreas kidney, pancreas after kidney) might be preferred. The answer to this question is however hampered by the fact that only observational data are available, and that accordingly, selection bias might potentially blur the interpretation of what we find in the literature. As such, having an idea as to what extent only the most optimal patients with diabetes are accepted for transplantation is important for correct interpretation of the observational data. This information, together with information on the outcome of transplantation, can help us to formulate advice on whether we should promote more transplantation in patients with diabetes, or rather refrain from doing so.

- Patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) mostly have complex comorbidity. In the post-transplantation period, immunosuppressive medication can deteriorate glycaemic control and worsen already existing vascular comorbidity. On the other hand, survival and QoL when remaining on dialysis might also be far from optimal. Therefore, we need to ascertain whether patients with diabetes could benefit from kidney transplantation, in terms of major outcomes. It is also important to elucidate whether a specific type of transplantation has better outcomes over another.

  - What did we find?

    We retrieved 12 studies for evaluating the potential selection bias for patients for transplantation (see Supplementary data extraction tables). Most studies were consistent with the hypothesis that compared with CKD patients without diabetes, those with diabetes are less likely to be waitlisted. Most guidelines recommend more extensive screening in patients with diabetes [60–62].

    No randomized controlled studies for any form of transplantation in patients with diabetes and CKD stage 5 were identified.

    We found 21 papers reporting observational data. Eight additional studies were identified by hand searching the reference lists of previously identified papers. The majority of the studies suffered from methodological limitations and were at high risk of different forms of bias. The studies reporting on hard endpoints such as mortality or graft outcome were mostly large registry-based patient populations. Some reported data from a single centre [63–69] with a high potential of centre bias, limiting generalizability. Also, not all studies distinguished type 1 from type 2 diabetes in their evaluation of outcome of transplantation versus remaining on dialysis [70] or in the outcome of a pancreas graft [63]. Most importantly, most studies suffered from a high risk of selection bias as patients remaining on the waiting list might have different characteristics from those actually transplanted (such as non-compliance, smoking, increased cardiovascular comorbidity or high immunization) which can affect their outcome and which mostly is not accounted for in the survival analysis.

    Some studies stratified their analysis according to diabetes status [71–73], whereby the adjusted mortality risk is higher
## Table 5. Observational studies on outcome after different modalities of transplantation in patients with type 1 diabetes

<table>
<thead>
<tr>
<th>Study</th>
<th>Time Period</th>
<th>Mean Age</th>
<th>Subjects</th>
<th>1-year patient survival</th>
<th>5-year patient survival</th>
<th>7-year patient survival</th>
<th>10-year patient survival</th>
<th>1-year kidney graft survival</th>
<th>5-year kidney graft survival</th>
<th>7-year kidney graft survival</th>
<th>10-year kidney graft survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rayhill et al. [66] 2000</td>
<td>1986–1996</td>
<td>39</td>
<td>805</td>
<td>99% haplo-identical LRDK, 96% SPK and 94% DKD</td>
<td>85% haplo-identical LRDK, 88% SPK and 72% DKD</td>
<td>94% haplo-identical LRD</td>
<td>87% SPK, 86% DKD</td>
<td>72% haplo-identical LRD</td>
<td>78% SPK, 64% DKD</td>
<td>73% SPK and 64% DKD</td>
<td>57% for SPK and 45% for DKD</td>
</tr>
<tr>
<td>Bunnapradist et al. [225] 2003</td>
<td>1994–1997</td>
<td>41</td>
<td>6016</td>
<td>94% for SPK versus 85% for DKD</td>
<td>95% for LRDK versus 87% for SPK and 72% for DKD</td>
<td>94% for SPK versus 79% for LRDK and 63% for DKD</td>
<td>90% for SPK versus 75% for LRDK</td>
<td>87% for SPK versus 60% for DKD</td>
<td>67% for SPK versus 57% for LRDK and 36% for DKD</td>
<td>57% for SPK versus 45% for LRDK versus 30% for DKD</td>
<td></td>
</tr>
<tr>
<td>Lindahl et al. [68] 2013</td>
<td>1983–2010</td>
<td>47</td>
<td>630</td>
<td>94% for SPK versus 85% for DKD</td>
<td>94% for LRDK versus 72% for SPK and 64% for DKD</td>
<td>94% for SPK versus 72% for LRDK</td>
<td>90% for SPK versus 60% for DKD</td>
<td>86% for SPK versus 56% for LRDK</td>
<td>78% for SPK versus 45% for LRDK</td>
<td>75% for SPK versus 36% for LRDK</td>
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</tr>
<tr>
<td>Mohan et al. [69] 2003</td>
<td>1992–2002</td>
<td>47</td>
<td>101</td>
<td>96% for SPK versus 89% for DKD</td>
<td>93% for SPK versus 78% for DKD</td>
<td>93% for SPK versus 76% for DKD</td>
<td>94% KTA</td>
<td>58% KTA</td>
<td>85.2% SPK versus 70.0% KTA</td>
<td>85% for SPK versus 75% for DKD</td>
<td></td>
</tr>
<tr>
<td>La Rocca et al. [64] 2001</td>
<td>1984–1998</td>
<td>46</td>
<td>206</td>
<td>ESRD type 1 DM (n = 351)</td>
<td>77.4% SPK versus 56.0% KTA versus 39.6% WL</td>
<td>77.4% SPK versus 56.0% KTA versus 39.6% WL</td>
<td>77.4% SPK versus 56.0% KTA versus 39.6% WL</td>
<td>77.4% SPK versus 56.0% KTA versus 39.6% WL</td>
<td>77.4% SPK versus 56.0% KTA versus 39.6% WL</td>
<td>77.4% SPK versus 56.0% KTA versus 39.6% WL</td>
<td></td>
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<tr>
<td>Young et al. [78] 2009</td>
<td>2000–2007</td>
<td>42</td>
<td>1362</td>
<td>type 1 DM who received a kidney transplant (n = 1362)</td>
<td>87% LRDK and SPK versus 75% DKD</td>
<td>87% LRDK and SPK versus 75% DKD</td>
<td>78% LRDK versus 66% DKD</td>
<td>78% LRDK versus 66% DKD</td>
<td>78% LRDK versus 66% DKD</td>
<td>78% LRDK versus 66% DKD</td>
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<tr>
<td>Waki et al. [90] 2012</td>
<td>1995–2002</td>
<td>44</td>
<td>1088</td>
<td>type 1 DM who received a kidney transplant (n = 1088)</td>
<td>96.4% for SPK versus 89.6% for DKD</td>
<td>96.4% for SPK versus 89.6% for DKD</td>
<td>78.2% for SPK versus 65.5% for KTA</td>
<td>78.2% for SPK versus 65.5% for KTA</td>
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<td></td>
</tr>
<tr>
<td>Weiss et al. [81] 2009</td>
<td>1997–2005</td>
<td>40</td>
<td>9630</td>
<td>type 1 DM on SPK waiting list (n = 9630)</td>
<td>95.9% SPK versus 92.2% LRDK versus 95.6% DKD</td>
<td>95.9% SPK versus 92.2% LRDK versus 95.6% DKD</td>
<td>88.6% SPK versus 80.0% LRDK versus 73.9% DKD</td>
<td>88.6% SPK versus 80.0% LRDK versus 73.9% DKD</td>
<td>88.6% SPK versus 80.0% LRDK versus 73.9% DKD</td>
<td>88.6% SPK versus 80.0% LRDK versus 73.9% DKD</td>
<td></td>
</tr>
<tr>
<td>Ojo et al. [79] 2001</td>
<td>1988–1998</td>
<td>34</td>
<td>13467</td>
<td>ESRD type 1 DM on SPK waiting list (n = 13467)</td>
<td>67% SPK versus 65% LRDK versus 46% DKD</td>
<td>67% SPK versus 65% LRDK versus 46% DKD</td>
<td>92.0% SPK versus 84.8% LRDK versus 90.3% DKD</td>
<td>92.0% SPK versus 84.8% LRDK versus 90.3% DKD</td>
<td>92.0% SPK versus 84.8% LRDK versus 90.3% DKD</td>
<td>92.0% SPK versus 84.8% LRDK versus 90.3% DKD</td>
<td></td>
</tr>
<tr>
<td>Poommipanit et al. [75] 2010</td>
<td>2000–2007</td>
<td>28</td>
<td>11966</td>
<td>type 1 DM on SPK waiting list (n = 11966)</td>
<td>99.2% PALK versus 95.6% SPK</td>
<td>91% PALK versus 87% SPK</td>
<td>86% PALK versus 77% SPK</td>
<td>86% PALK versus 77% SPK</td>
<td>86% PALK versus 77% SPK</td>
<td>86% PALK versus 77% SPK</td>
<td></td>
</tr>
<tr>
<td>Kleinclauss et al. [63] 2009</td>
<td>1995–2003</td>
<td>45</td>
<td>250</td>
<td>type 1 or 2 LDL recipients (n = 250)</td>
<td>98% PAK versus 100% KTA-eligible</td>
<td>98% PAK versus 100% KTA-eligible</td>
<td>71% PAK versus 76% KTA-eligible</td>
<td>71% PAK versus 76% KTA-eligible</td>
<td>71% PAK versus 76% KTA-eligible</td>
<td>71% PAK versus 76% KTA-eligible</td>
<td></td>
</tr>
</tbody>
</table>

DKD, deceased kidney donor; KTA, kidney transplant alone; LR(R)DK, living (related) kidney donor; SPK, simultaneous kidney pancreas transplant; WL, waitlisted patients; PA(L)K, pancreas after kidney (from living donor).

"It is unclear whether this is perhaps a mistake in the original data, as 5-year graft KTA was reported to be 58%, whereas 5-year patient survival was reported to be 57%."
in patients with versus without diabetes [73, 74]. Patient survival is better in CKD stage 5 patients with diabetes who actually had a transplant versus those remaining on the waiting list [70, 73].

The studies dealing with the different options for type 1 diabetes are summarized in Table 5. The table intends to help physicians to discuss the different options and their pros/cons with the patient to support shared decision-making. Patients receiving a pancreas after kidney transplantation had better graft survival compared with those who were eligible but did not receive a pancreas graft or only after 5 years or more. Other analyses have demonstrated superior outcomes of pancreas transplantation after living donor kidney versus simultaneous pancreas and kidney [75]. The survival benefit of simultaneous pancreas–kidney compared with kidney transplantation alone in patients with type 1 diabetes appeared inconsistent and also depended on the modality of kidney transplantation (cadaveric versus living donor kidney), the time point of assessment and the adjustment for confounders. Changes in patient selection criteria, donor criteria and surgical and immunosuppressive treatment can also explain changes in outcome according to time period [68]. Early survival benefit in simultaneous pancreas kidney versus kidney transplant alone often is not observed with even increases in early post-transplantation mortality [76]. Long-term outcome is in most, but not all, studies better with simultaneous pancreas–kidney than with kidney transplantation alone [65, 67–69, 76]. In an older UNOS analysis, simultaneous pancreas–kidney recipients had a higher mortality than living donor kidney recipients through the first 18 months post-transplantation, but they had a lower relative hazard thereafter [77]. In the univariate survival analysis, no difference in outcome for patient and graft [78] was observed between patients receiving a simultaneous pancreas–kidney versus a living donation kidney alone. In contrast, long-term patient and graft survival in the multivariate model was inferior in the simultaneous pancreas kidney versus the living donation kidney group. Longer term survival is reported to be superior with simultaneous pancreas–kidney versus solitary renal transplantation in other studies [79, 80]. Pancreas graft failure in the first year seems to attenuate or even abolish the beneficial long-term effects of SPK versus kidney transplantation alone [81] as it decreases both graft and patient survival [82], and also having preserved kidney graft function at year 1 seems to be an important modulating factor [77].

Analyses of QoL or intermediate endpoints such as neuropathy [83], retinopathy [84] or cardiovascular surrogate markers [85–87] without exception included small patient numbers and/or lacked adjustment for confounders. They compare different patient populations (for instance, simultaneous pancreas–kidney transplantation with failed versus functioning pancreas graft) [88, 89] with—in the QoL studies—numerous, and not always consistent, uses of valid assessments of physical state, cognitive functioning and mental health. Comparing QoL of patients receiving simultaneous pancreas–kidney transplantation with that of patients losing or refusing their pancreatic graft [89] might overestimate the differences in perceived QoL between the groups.

• How did we translate this into the statement?

We recommend education on the different options of transplantation and their expected outcomes for patients with diabetes and CKD stage 4 or 5 and who are deemed suitable for transplantation (see Table 5) (1D).

Only observational data are available to support guidance in this area.

Statements only for patients with type 1 diabetes:
We suggest insulin-dependent patients (type 1 diabetes) should be considered for simultaneous pancreas–kidney transplantation (2C).

We suggest against islet transplantation after kidney transplantation with the aim to improve survival (2C).

We suggest pancreas grafting to improve survival after kidney transplantation (2C).

The same risk of selection bias might be present in the studies on simultaneous pancreas–kidney transplantation for patients with type 1 diabetes. Simultaneous pancreas–kidney transplantation is mostly performed at high-volume centres, which most likely hampers generalizability of outcomes. The wealthiest patients are also likely to be allocated to simultaneous pancreas–kidney transplantation, receive the highest quality organs [90] and more often receive a pre-emptive transplant [67].

Figure 3 provides a potential decision flow chart for transplantation modality selection in patients with type 1 diabetes. If a living donor is available, the guideline development group judges that (pre-emptive) living donation should be preferred, as it increases the donor pool, and the results are not inferior to simultaneous pancreas–kidney transplantation. If no living donor is available, a simultaneous pancreas–kidney transplant should be preferred, provided the patient is considered fit enough to survive the increased peri-operative risk.

Statements only for patients with type 2 diabetes:
We recommend against pancreas or simultaneous kidney-pancreas transplantation (1D).

We recommend diabetes per se should not be considered a contraindication to kidney transplantation in patients who otherwise comply with inclusion and exclusion criteria for transplantation (1C).

There is a high risk for selection bias in the observational data, as the access to the waiting list is hampered for patients with diabetes. This is consistent with the observation that most guidelines recommend more intense screening, especially
for cardiovascular disease [60], in patients with diabetes. As a result, it should be taken into account that, for patients with diabetes, the outcomes observed after transplantation are only valid for those without substantial comorbidity, i.e who passed our current pre-transplant screening procedures [60]. For this group of patients with type 2 diabetes, the presence of diabetes does not appear to be an additional risk factor per se; as a consequence, the guideline development group judges that diabetes in itself should not be a contraindication for transplantation, provided that the patient complies with current pre-transplant screening recommendations.

What do the other guidelines say?

We did not find any guidelines providing guidance on this topic.

Suggestions for future research

1. Prospective multicentre observational studies comparing hard endpoints between living donor kidney transplantation and simultaneous pancreas–kidney transplantation in patients with type 1 diabetes, appropriately adjusted for comorbidity.

2. Prospective, adequately powered multicentre studies to assess the effect of transplantation compared with remaining on the waiting list in patients with type 1 or 2 diabetes on prespecified (surrogate) endpoints, such as cardiovascular events, vascular stiffness, intima-media thickness and retinopathy.

8. CHAPTER 2. ISSUES RELATED TO GLYCAEMIC CONTROL IN PATIENTS WITH DIABETES AND CKD STAGE 3B OR HIGHER (eGFR <45 mL/min)

Chapter 2.1

A. Should we aim to lower HbA1C by tighter glycaemic control in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min)?

B. Is an aggressive treatment strategy (in number of injections and controls and follow-up) superior to a more relaxed treatment strategy in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) and using insulin?

Statements

2.1.1 We recommend against tighter glycaemic control if this results in severe hypoglycaemic episodes (1B).

2.1.2 We recommend vigilant attempts to tighten glycaemic control with the intention to lower HbA1C when values are >8.5% (69 mmol/mol) (1C).

2.1.3 We suggest vigilant attempts to tighten glycaemic control with the intention to lower HbA1C according to the flow chart in Figure 4 in all other conditions (2D).

2.1.4 We recommend intense self-monitoring only to avoid hypoglycaemia in patients at high risk for hypoglycaemia (2D).

Advice for clinical practice

• Severity of hypoglycaemic episodes are defined as ‘mild’ when it can be treated by the patient himself and as ‘severe’ when assistance is required.

• The most important concern is to avoid episodes of hypoglycaemia.

• Empower patients at moderate and high risk for hypoglycaemia to perform regular follow-up of blood glucose level by using validated point of care devices.

• Patients and conditions at low, moderate and high risk for hypoglycaemic episodes are depicted in Figure 5.

Rationale

• Why this question?

It is unclear whether in this specific patient cohort, aiming at a lower HbA1C value by tightening glycaemic control results in improved outcomes, in terms of mortality and morbidity. There is some concern that excess mortality...
and morbidity can be induced by increasing the risk for (severe) hypoglycaemia.

It is unclear whether maintaining or promoting intensive glucose control by regular auto-control, more regular follow-up visits and educational or patient empowerment programmes helps to decrease diabetes-specific complications in this specific patient population. These programmes are labour intensive and expensive and thus have an important impact on health care resources.

- What did we find?

We found one recent systematic review in dialysis patients [91] on the association between HbA1C and outcome that included 10 studies (83,684 participants) (9 observational studies and 1 secondary analysis of a randomized trial). After adjustment for confounders, patients with baseline HbA1c levels >69 mmol/mol (8.5%) versus 48–57 mmol/mol (6.5–7.4%) had increased mortality (HR 1.14; 95% CI 1.09–1.19). Likewise, patients with a mean HbA1c value >69 mmol/L (8.5%) had a higher adjusted risk of mortality (HR 1.29; 95% CI 1.23–1.35). In incident patients, mean HbA1c levels <36 mmol/mol (5.4%) were also associated with increased mortality risk (HR 1.29; 95% CI 1.23–1.35).

A recent randomized trial demonstrated that adding saxagliptin to the existing treatment, resulted in a decrease of HbA1C and a higher percentage of patients reaching an HbA1C <7%, but not in an improvement in cardiovascular outcomes [92].

We did not retrieve any other data collected specifically in patients with diabetes and with CKD stage 3b or higher (eGFR <45 mL/min). Effort was made to extract data specifically on patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) in general diabetes studies, but this was hampered by the fact that in most studies, presence of CKD stage 3b or higher (eGFR <45 mL/min) is an exclusion criterion, or data were not reported separately for patients with CKD.
stage 3b or higher (eGFR <45 mL/min).

A high-quality systematic review demonstrated lack of benefit of tighter glycaemic control as assessed by an HbA1C <7 (53 mmol/mol) or 7.5% (59 mmol/mol) [93], whereas there was a clear risk for enhanced hypoglycaemia episodes when glycaemic control is tightened [93].

We found one high-quality systematic review assessing the effectiveness of self-monitoring blood glucose levels in people with non-insulin-treated type 2 diabetes compared with clinical management without self-monitoring [97]. Although there was an improvement in HbA1C levels in the self-monitoring group (~2.7 mmol/mol), there was no convincing clinically meaningful effect.

• How did we translate the evidence into the statement? Which considerations were taken into account (GRADE)?

As data in our target population (patients with diabetes and CKD stage 3b or higher) are scant, the guideline group considered a two-tiered approach: (i) evaluate the available evidence in the general population with diabetes; (ii) evaluate which considerations made our target population special in this regard, and would have an impact on translation of the data from the general diabetes population.

We recommend against tighter glycaemic control if this results in or increases the risk for severe hypoglycaemic episodes (1B).

We recommend vigilant attempts to tighten glycaemic control with the intention to lower HbA1C when values are >8.5% (69 mmol/mol) (1C).

We suggest vigilant attempts to tighten glycaemic control with the intention to lower HbA1C according to the flow chart in Figure 4 in all other conditions (2D).

Under these conditions, an intense self-monitoring with the sole aim to attain lower glycaemic values is difficult to defend, as it is linked with uncertain benefit. In addition, using intense self-monitoring did not result in an improvement of HbA1C values, and accordingly, self-monitoring can thus not be recommended if the only aim is to reduce HbA1C. However, in patients at risk for hypoglycaemia (Figure 5), i.e. mostly those taking active medication with a high risk of hypoglycaemia, e.g. insulin, regular monitoring should be performed to avoid overshooting and hypoglycaemia.

• What do other guidelines say?

No guideline specifically targets patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min).

In their 2012 position statement [94], the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD) also promote taking into account individual patient characteristics to determine the most optimal level of glycaemic control.

In their 2012 update of their clinical practice guideline on diabetes and CKD, KDOQI [95] recommends a target HbA1c of around 7.0% to prevent or delay progression of the micro-vascular complications of diabetes, including diabetic kidney disease; they further recommend not aiming for an HbA1c target of <7.0% in patients at risk of hypoglycaemia, and suggest that the target of HbA1c can be extended above 7.0% in individuals with comorbidities or limited life expectancy and risk of hypoglycaemia. In their rationale, they explain that the risk for hypoglycaemia outweighs the potential benefits of reduced micro-vascular complications in patients with advanced stages of CKD.

Suggestions for further research

1. Evaluate whether it is glycaemic variability and specifically hypoglycaemia that contributes to cardiovascular risk, rather than average blood glucose level.

2. A study of intensive versus standard control (HbA1c <53 mmol/mol versus <69 mmol/mol), specifically in patients with diabetes and CKD stage 3b–5 using drugs with very low risk to induce hypoglycaemia, is warranted.

Chapter 2.2. Are there better alternatives than HbA1c to estimate glycaemic control in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²)?

We recommend intense self-monitoring only to avoid hypoglycaemia in patients at high risk for hypoglycaemia (2D).
Advice for clinical practice

- Continuous glucose measurement devices can be considered in high-risk patients in whom a very tight control of glycaemia is deemed of benefit.
- The association between HbA1C and longer term glycaemic control might be different in patients with versus without CKD stage 3b or higher (eGFR <45 mL/min), and this both for the absolute value as well as for the slope of the association curve.
- The following factors are potentially associated with a lower than expected HbA1C:
  - decreased red blood cell survival
  - increased red blood cell formation (use of iron, RhuEpo).
- The following factors are potentially associated with a higher than expected HbA1C:
  - accumulation of uraemic toxins.

Rationale

Why this question?

Although in many countries measurement of HbA1c is the cornerstone for diagnosis and management of diabetes mellitus in routine clinical practice, the role of this biomarker in reflecting long-term glycaemic control in patients with CKD stage 3b or higher (eGFR <45 mL/min) has been questioned. As a different association between glycaemic control and morbidity/mortality might be observed in patients with and without CKD stage 3b or higher (eGFR <45 mL/min), we wanted to summarize the current knowledge and evidence of the use of HbA1C and of alternative glycaemic markers [glycated albumin, fructosamine, 1,5-anhydroglucitol (1,5-AG) and continuous glucose monitoring] in this specific patient population.

What did we find?

The guideline development group conducted a narrative review [96] to explore different methods to assess longer term glycaemic control, and their accuracy in patients with CKD stage 3b or higher (eGFR <45 mL/min), the findings are summarized in Table 6.

How did we translate this into the statements?

Due to the availability of relatively inexpensive and routinely measured HbA1c assays and the inconsistent or limited data to prove the superiority of other glycaemic markers (glycated albumin, fructosamine, 1,5-AG and continuous glucose monitoring) at this time, the guideline development group judges that HbA1c should remain the reference standard for glycaemic monitoring in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min).

In the future, continuous subcutaneous glucose monitoring seems to be a promising method to correctly evaluate glycaemic control in patients with diabetes undergoing HD and in whom more intense glycaemic control is judged to be of relevance.

Suggestions for future research

1. Prospective studies testing pre-specified diabetes control targets based on glycated albumin and continuous glucose measurements in order to determine whether morbidity and mortality would be reduced with intensive glycaemic control using these measurements as reference target, and this specifically in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min).
2. Evaluate the role, if any, of continuous glucose monitoring systems for determining therapeutic adjustments for patients with diabetes treated with renal replacement therapy.

Chapter 2.3

A. Is any oral drug superior to another in terms of mortality/complications/glycaemic control in patients with diabetes type 2 and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²)?

B. In patients with diabetes type 2 and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), is maximal oral therapy better than starting/adding insulin at an earlier stage?

Statements

2.3.1 We recommend metformin in a dose adapted to renal function as a first line agent when lifestyle measures alone are insufficient to get HbA1C in the desired range according to Figure 4 (1B).

2.3.2 We recommend adding on a drug with a low risk for hypoglycaemia (fig 5, 6 and 7) as additional agent when improvement of glycaemic control is deemed appropriate according to Figure 4 (1B).

2.3.3 We recommend instructing patients to temporarily withdraw metformin in conditions of pending dehydration, when undergoing contrast media investigations, or in situations with an increased risk for AKI (1C).

Advice for clinical practice

- Consider instructing patients by using credit-card type flyers on when to temporarily withdraw metformin.
- Conditions considered as low, moderate or high risk for hypoglycaemia are depicted in Figure 5.
- Hypoglycaemia risk for different drugs is presented in Figures 5 and 7.
- In patients with diabetes type 2 and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) who are on metformin, the
Table 6. Comparison of the different glycaemic markers in patients with diabetes and CKD stage 3b or higher

<table>
<thead>
<tr>
<th>Marker</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>• Marker of longer-term glycaemic concentrations</td>
<td>• Falsey increased values with iron deficiency, vitamin B12 deficiency, decreased erythropoiesis, alcoholism, chronic renal failure, decreased erythrocyte pH, increased erythrocyte lifespan, splenectomy, hyperbilirubinaemia, carbamylated haemoglobin, alcoholism, intake of large doses of aspirin, chronic opiate use</td>
</tr>
<tr>
<td></td>
<td>• Excellent standardization of HbA1c assays</td>
<td>• Falsely decreased values have been reported after administration of erythropoietin, iron or vitamin B12; with reticulocytosis, chronic liver disease, ingestion of aspirin, vitamin C, vitamin E, certain haemoglobinopathies, increased erythrocyte pH, a decreased erythrocyte lifespan, haemoglobinopathies, splenomegaly, rheumatoid arthritis, drugs such as antiretrovirals, ribavirin and dapsone, hypertriglyceridaemia</td>
</tr>
<tr>
<td></td>
<td>• Universally available primary reference measurement system</td>
<td>• Variable changes have been seen in patients with HbF, haemoglobinopathies, methaemoglobin, genetic determinants</td>
</tr>
<tr>
<td></td>
<td>• Scientific evidence on association with outcomes from several trials</td>
<td>• Values can be influenced by lipaemia, hyperbilirubinaemia, haemolysis, increased uric acid, uraemia, intake of high doses of aspirin, low serum protein concentrations/nutritional status, age, albuminuria, cirrhosis, thyroid dysfunction and smoking</td>
</tr>
<tr>
<td></td>
<td>• In comparison with blood glucose, less sensitivity to preanalytical variables, lower within subject biological variability, little/no diurnal variations, little/no influence from acute stress and little/no influence from common drugs which are known to influence glucose metabolism</td>
<td>• Concentration is inversely influenced by body mass index, body fat mass and visceral adipose tissue</td>
</tr>
<tr>
<td>Glycated albumin</td>
<td>• Excellent separation of the HbA1c fraction from other haemoglobin adducts and with no interference from carbamylated haemoglobin due to technological advances in HbA1c measurement</td>
<td>• Different reference ranges depending on the applied method</td>
</tr>
<tr>
<td></td>
<td>• Measure of shorter-term glycaemic control (2–3 weeks)</td>
<td>• Limited data, especially on the impact of using it as a target</td>
</tr>
<tr>
<td>Fructosamine</td>
<td>• Not influenced by gender, erythrocyte lifespan, erythropoietin therapy or serum albumin concentration</td>
<td>• Expensive, time consuming, not widely available</td>
</tr>
<tr>
<td></td>
<td>• Significant association with markers of vascular injury</td>
<td>• Contradictory results concerning the correlation between fructosamine and mean glucose concentrations in patients with CKD stage 3b or higher</td>
</tr>
<tr>
<td></td>
<td>• Correlates with average glucose levels in the previous 10–14 days</td>
<td>• Values can be influenced by nephrotic syndrome, thyroid dysfunction, glucocorticoid administration, liver cirrhosis, icterus</td>
</tr>
<tr>
<td>1,5-anhydroglucitol</td>
<td>• Reflects day-to-day changes in glucose levels.</td>
<td>• Concentration in uraemic patients may be influenced by a number of variables other than glycaemia, including hypoalbuminaemia, hyperuricaemia</td>
</tr>
<tr>
<td></td>
<td>• Retained metabolic inertness, steady-state levels in all tissues and negligible influence of sampling conditions such as collection time, body weight, age, sex and food intake of the subjects</td>
<td>• Within-subject variation is higher than that for HbA1c</td>
</tr>
<tr>
<td>Continuous glucose</td>
<td>• Theoretically the most ideal marker for glycaemic control</td>
<td>• Poorer performance in identifying cases of undiagnosed diabetes in comparison with other glycaemic markers</td>
</tr>
<tr>
<td>measurement</td>
<td>• Allows examination of short-term glycaemic changes around the time of dialysis</td>
<td>• Influenced by traditional Chinese herbal drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Limitations for use in subjects with renal tubular acidosis, or advanced renal disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not widely available, limited data on its clinical everyday value</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exhaustion of the sensor, limited data</td>
</tr>
</tbody>
</table>

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**FIGURE 6:** Dose recommendations in CKD.

<table>
<thead>
<tr>
<th></th>
<th>CKD-1</th>
<th>CKD-2</th>
<th>CKD-3</th>
<th>CKD-4</th>
<th>CKD-5/6D</th>
<th>CKD-5/5D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>No adjustments</td>
<td>1.5g-50g mg/day*</td>
<td>500mg/day**</td>
<td>Consider carefully/Awaiting further data</td>
<td>To be avoided</td>
<td></td>
</tr>
<tr>
<td>Chlorpropamide</td>
<td>No adjustments</td>
<td>100-125mg/day</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetohexamide</td>
<td>To be avoided</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Tolazamide</td>
<td>To be avoided</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Tolbutamide</td>
<td>75-150mg, 1-3 times/day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glicazide</td>
<td>No adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gliclazide</td>
<td>Start at low doses and dose titration every 1-4 weeks</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Glyburide</td>
<td>To be avoided</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Glimeperide</td>
<td>Reduce dosage to 1 mg/day</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Gliquidone</td>
<td>No adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repaglinide</td>
<td>No adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nateglinide</td>
<td>No adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acarbose</td>
<td>No adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miglitol</td>
<td>Limited experience available</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**FIGURE 7:** Impact of different classes of glycaemia-lowering drugs on different outcomes. (For full data extraction: see Supplementary tables) and Arnouts et al. [110]. Dark green denotes evidence for beneficial effect; red indicates evidence for negative effect; yellow represents not investigated or insufficient data; salmon denotes evidence for weak negative effect; aquamarine represents evidence for neutral to weak positive effect; dark blue indicates evidence for lack of effect/neutral.

<table>
<thead>
<tr>
<th></th>
<th>All-cause mortality</th>
<th>Cardiovascular events</th>
<th>Risk of hypoglycaemia</th>
<th>Weight gain</th>
<th>HbA1C change</th>
<th>dose adaptation in advanced CKD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Chlorpropamide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Avoid</td>
</tr>
<tr>
<td>Acetohexamide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Avoid</td>
</tr>
<tr>
<td>Tolazamide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Avoid</td>
</tr>
<tr>
<td>Tolbutamide</td>
<td></td>
<td></td>
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<td></td>
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<td>Empagliflozin</td>
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<td>Exenatide</td>
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<td>Lixisenatide</td>
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<td>Pramlintide</td>
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SGLT-2 inhibitors: Dapagliflozin, Empagliflozin; SGLT-2 inhibitors: lixisenatide, pramlintide; DPP-IV inhibitors: exenatide, lixisenatide; Incretin mimetics: lixisenatide, pramlintide; SGLT-2 inhibitors: dapagliflozin, empagliflozin; GLP-1 receptor agonists: exenatide, lixisenatide; Pramlintide: pramlintide; Acalborbide: acarbose; Miglitol: miglitol; DPP-IV inhibitors: dapagliflozin, empagliflozin; SGLT-2 inhibitors: lixisenatide, pramlintide; DPP-IV inhibitors: exenatide, lixisenatide; Incretin mimetics: lixisenatide, pramlintide; SGLT-2 inhibitors: dapagliflozin, empagliflozin; GLP-1 receptor agonists: exenatide, lixisenatide; Pramlintide: pramlintide; Acalborbide: acarbose; Miglitol: miglitol; DPP-IV inhibitors: dapagliflozin, empagliflozin; SGLT-2 inhibitors: lixisenatide, pramlintide; DPP-IV inhibitors: exenatide, lixisenatide; Incretin mimetics: lixisenatide, pramlintide; SGLT-2 inhibitors: dapagliflozin, empagliflozin; GLP-1 receptor agonists: exenatide, lixisenatide; Pramlintide: pramlintide; Acalborbide: acarbose; Miglitol: miglitol; DPP-IV inhibitors: dapagliflozin, empagliflozin; SGLT-2 inhibitors: lixisenatide, pramlintide; DPP-IV inhibitors: exenatide, lixisenatide; Incretin mimetics: lixisenatide, pramlintide; SGLT-2 inhibitors: dapagliflozin, empagliflozin; GLP-1 receptor agonists: exenatide, lixisenatide; Pramlintide: pramlintide; Acalborbide: acarbose; Miglitol: miglitol; DPP-IV inhibitors: dapagliflozin, empagliflozin; SGLT-2 inhibitors: lixisenatide, pramlintide; DPP-IV inhibitors: exenatide, lixisenatide; Incretin mimetics: lixisenatide, pramlintide; SGLT-2 inhibitors: dapagliflozin, empagliflozin; GLP-1 receptor agonists: exenatide, lixisenatide; Pramlintide: pramlintide; Acalborbide: acarbose; Miglitol: miglito
decision to withhold the drug 48 h before and after administration of contrast media should be taken by the treating physician, balancing the probability of emergence of contrast-induced nephropathy (type and amount of contrast, intravenous versus intra-arterial), and presence of other coexisting factors that might cause sudden deterioration of kidney function (dehydration, use of NSAID, use of inhibitors of the RAAS system) against the potential harms by stopping the drug (which should be considered low in view of the short period that it should be withheld).

- As renal clearances of different glycaemia-lowering agents might differ, combining different glycaemia-lowering drugs in a one pill formulation can lead to overdosing of one of the constituents in patients with CKD stage 3b or higher.

**Rationale**

- **Why this question?**
  
  The achievement of good glycaemic control is postulated to be one of the cornerstones for preventing and delaying progression of microvascular and macrovascular complications in patients with both diabetes and CKD. New research suggests that commonly prescribed drugs for type 2 diabetes may not all be equally effective at preventing death and cardiovascular diseases, such as heart attacks and stroke.

  Each drug category has unique advantages and disadvantages, and with this question we aim to put them in the context of rational, evidence-based therapeutic strategies. This question also specifically addresses whether adding another oral hypoglycaemic therapy provides a better efficacy/safety profile than starting/adding insulin and whether specific types of drugs should be preferred over others.

- **What did we find?**
  
  We did not retrieve any RCTs evaluating our question on superiority of one drug over the other in the specific population of patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²). Some drugs need dose adaptation when administered in patients with renal insufficiency (see Table 6). The different classes of glycaemia-lowering drugs and their main mechanisms of action are listed in Table 7.

  One study [97] showed a high rate of hypoglycaemia when using insulin when compared with glyburide in patients with CKD, but apparently, the reported risk was lower than in patients with normal kidney function. Another study showed a high rate of hypoglycaemia in patients with CKD treated with sulphonylureas [98].

  Three studies analysing the effects of DPP4 inhibitors in patients with CKD (one sitagliptin [99], one vildagliptin [100], two saxagliptin [101, 102]) were retrieved. Most of these studies only analysed surrogate endpoints, mostly reduction of HbA1C levels. None of these studies reported on higher incidence of side effects when compared with non-CKD patients. Only one study was performed in ESRD patients (saxagliptin), demonstrating no effect on all-cause or cardiovascular comorbidity [92]. There was however a trend for an increased risk for the prescribed secondary outcomes of need for hospitalization for congestive heart failure (3.5 versus 2.8% in saxagliptin versus placebo group, hazard ratio 1.27, 95% CI 1.07–1.51). One study [103] evaluated the effect of liraglutide in CKD, reporting an increased frequency of nausea. Another study [104] demonstrated that risk of hypoglycaemia was lower with meglitinides when compared with insulin in patients on HD. One study [105] demonstrated that the use of mitiglinide resulted in a mean decrease of HbA1C of 0.8%.

  With regard to the second-line add-on treatment, we found in our target cohort of patients with diabetes and eGFR <45 mL/min/1.73 m² 11 manuscripts reporting on 10 studies: 3 RCTs, 5 prospective observational and 2 retrospective observational cohorts. The study by Lukashevich [100] is a double-blind randomized study on vildagliptin versus placebo added to already existing glycaemia-lowering treatment. In patients with diabetes and CKD stage 3 (vildagliptin 165/placebo 129) or CKD stage 5 (vildagliptin 124/placebo 97) renal impairment, vildagliptin resulted in lower HbA1C than placebo after a follow-up of 24 weeks. No hard endpoints were reported. After 1 year, the between-treatment difference in adjusted mean change in HbA1C was $-0.4 \pm 0.2\%$ (P = 0.005) in CKD stage 3 (baseline = 7.8%) and $-0.7 \pm 0.2\%$ (P <0.0001) in CKD stage 5 (baseline = 7.6%). In patients with CKD stage 3, similar proportions of patients experienced any adverse event (AE) (84 versus 85%), any serious adverse event (SAE) (21 versus 19%), any AE leading to discontinuation (5% versus 6%) and death (1% versus 0%) with vildagliptin and placebo, respectively. This was also true for patients with CKD stage 5: AEs (85% versus 88%), SAEs (25% versus 25%), AEs leading to discontinuation (10% versus 6%) and death (3% versus 2%). Of note, the first authors of these papers are employees of the pharmaceutical company producing the drug.

  Nowicki et al. [101] present one randomized double-blind study (12 weeks) and its long-term follow-up (52 weeks) conducted in 170 patients with type 2 diabetes and CKD randomized to saxagliptin ($n = 85$) or placebo ($n = 85$). The DPPIV inhibitor saxagliptin confers sustained improvement in HbA1C in patients with diabetes and retains a good safety profile when compared with placebo in patients with diabetes and creatinine clearance <50 mL/min. The study by McGill [106] is a prospective (1 year) double-blind randomized study conducted in 133 patients with type 2 diabetes randomized to linagliptin ($n = 68$) or placebo ($n = 65$). Linagliptin demonstrated significant improvement in glycaemic control with a risk of hypoglycaemia similar to placebo.

  In the general population with diabetes, several meta-analyses comparing different combinations of oral glycaemia-lowering drugs or insulin and providing data on all-cause mortality, cardiovascular events, risk for hypoglycaemia, weight gain and HbA1C control were retrieved and summarized (see Figure 7 and Supplementary data extraction tables of Chapter 2.3). Only one of these systematic reviews explicitly mentioned that they included patients with CKD stage 3b or higher. In none of the others was interaction of CKD versus no CKD on the reported outcomes taken into account.
Table 7. Oral glycaemia-lowering drugs: mechanisms of action

<table>
<thead>
<tr>
<th>Drug class</th>
<th>Mechanisms of action</th>
<th>Examples (alphabetical order)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biguanides</td>
<td>- Decrease hepatic glucose production</td>
<td>Metformin</td>
</tr>
<tr>
<td></td>
<td>- Increase insulin sensitivity</td>
<td>Acetohexamide, chlorpropamide, glibenclamide, glipizide, glyburide, gliimeperide, glipizide, gliquidone</td>
</tr>
<tr>
<td></td>
<td>- Increase insulin-mediated utilization of glucose in peripheral tissues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Decrease glucose intestinal absorption</td>
<td></td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>- Stimulate insulin secretion from the pancreas</td>
<td>Alogliptin, linagliptin, saxagliptin, sitagliptin, vildagliptin</td>
</tr>
<tr>
<td></td>
<td>- Closes K-ATP channels on β-cell plasma membranes</td>
<td>Nateglinide, repaglinide</td>
</tr>
<tr>
<td>Meglitinides</td>
<td>- Stimulate pancreatic insulin secretion by closing K-ATP channels on β-cell plasma membranes</td>
<td></td>
</tr>
<tr>
<td>Alfa glucosidase inhibitors</td>
<td>- Block the action of the α-glucosidase with reduced hydrolysis of complex saccharides</td>
<td>Acarbose, miglitol</td>
</tr>
<tr>
<td>Glitazones</td>
<td>- Reduce insulin resistance</td>
<td>Pioglitazone</td>
</tr>
<tr>
<td></td>
<td>- Increase glucose uptake in muscles and adipose tissue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Decrease hepatic glucose production</td>
<td></td>
</tr>
<tr>
<td>DPP-IV inhibitors</td>
<td>- Inhibit DPP-4, which inactivates endogenous incretins</td>
<td>Alogliptin, linagliptin, saxagliptin, sitagliptin, vildagliptin</td>
</tr>
<tr>
<td>Incretin mimetics</td>
<td>- Promote glucose dependent insulin secretion by pancreatic β cells</td>
<td>Exenatide, liraglutide, lixisenatide</td>
</tr>
<tr>
<td></td>
<td>- Suppress glucagon secretion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Slow gastric emptying</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Control gastric emptying and postprandial glucagon secretion</td>
<td></td>
</tr>
<tr>
<td>Amylin analogues</td>
<td>- Regulate glucose levels in response to food intake</td>
<td>Pramlintide</td>
</tr>
<tr>
<td></td>
<td>- Reduce food intake by increasing satiety</td>
<td></td>
</tr>
<tr>
<td>SLT-2 inhibitors</td>
<td>- Block the sodiumglucose transport protein subtype 2, thus increasing renal loss of glucose</td>
<td>Canagliflozin, dapagliflozin, empagliflozin</td>
</tr>
</tbody>
</table>

Metformin was the only drug that has a proven beneficial impact on all-cause and cardiovascular mortality. Risk of hypoglycaemia was reported to be low with metformin, glipizide, acarbose, DPP-IV inhibitors and the SGLT2 inhibitors. Metformin, acarbose, exenatide, liraglutide, lixisenatide, pramlintide and SGLT-T2 inhibitors were reported to be weight neutral, whereas DPP4 inhibitors, gliclazide, repaglinide and nateglinide were reported to slightly increase weight.

Based on a Cochrane review, there is no evidence to underpin the notion that CKD stage 3b or higher per se enhances the risk for lactic acidosis associated with metformin [107]. Although this Cochrane review was not restricted to patients with CKD stage 3b or higher, it also did not exclude this patient group.

Based on a systematic review of case reports on lactic acidosis, we did not find any evidence to support a consistent association between metformin and lactic acidosis (Supplementary data extraction tables). There was a signal that, in most of the cases, overdosing of metformin was present, although there was no consistent association between metformin levels and metabolic acidosis or lactate levels. Overdosing was either intentional or accidental due to inappropriate adaptation of dose to renal function. In the latter case, this was mostly due to an abrupt decrease of glomerular filtration rate (GFR) due to an intercurrent event.

- How did we translate the evidence into the statement? (GRADE)
- As there is insufficient data from our specific target population with diabetes type 2 and CKD stage 3b or higher (eGFR <45 mL/1.73 m² min), the guideline group decided, in line with the initial planned methodology, to evaluate how data from the general population with diabetes could be translated into our target population of patients with diabetes type 2 and CKD stage 3b or higher (eGFR <45 mL/1.73 m² min).

The guideline development group therefore decided that a first step was to evaluate whether drugs needed adaptation of dose in relation to renal function. Accordingly, a review of the pharmacokinetic data of glycaemia-lowering drugs was done (Supplementary data tables). Based on these data, the table in Figure 6 was constructed to guide dose adaptation in function of CKD stages.

As a second step, the guideline group wanted to evaluate which aspects of the treatment would be different in patients with diabetes type 2 versus without eGFR <45 mL/1.73 m² min. Based on interpretation of the available evidence, the guideline development group judged that particularly the higher risk for hypoglycaemia and the lower likelihood of improving hard endpoints by tightening the glycaemic control should be taken into account.

Therefore, the guideline development group considered that the first concern should always be not to increase the risk for severe hypoglycaemia. As a consequence, preference should go to drugs with a low risk for hypoglycaemia when administered in a dose adapted to renal function. Additional glycaemia-lowering drugs should only be started after careful consideration of their expected benefit, and taking into account their potential to cause hypoglycaemia, as visualized and summarized in Figures 5 and 7.

We recommend metformin in a dose adapted to renal function as a first line agent when lifestyle measures alone are insufficient to get HbA1C in the desired range according to Figure 4 (1B).
There is little doubt in general guidelines on management of type 2 diabetes that metformin should be the first-line glycaemia-lowering drug [94, 108] because of its beneficial impact on all-cause and cardiovascular mortality. In addition, metformin carries a low risk for hypoglycaemia. As a consequence, the guideline development group considered that metformin should be the first-line drug for all patients with type 2 diabetes up to a clearance of 30 mL/min because of its association with improved cardiovascular morbidity, the very low risk of hypoglycaemia and its weight-lowering properties. This position is also in agreement with recent insights into metformin therapy [109]. In any case, metformin dose should be adapted to renal function [110]. The guideline development group acknowledged that, despite its proven value, the use of metformin in patients with CKD remains controversial. Even below the threshold of 30 mL/min, the guideline development group considers the cost–benefit of metformin to be positive, but as less data are available [111, 114], some caution remains warranted. A recent systematic review published after the end of our official literature search confirmed the absence of any evidence for an increased risk of lactic acidosis, even in patients with an eGFR <30 mL/min/1.73 m² [108]. In another systematic review, Kajbaf et al. [112] report widely varying recommendations on the use of metformin in patients with renal failure in 51 different guidance documents. Some guidelines used qualitative criteria, whereas others used quantitative criteria, either serum creatinine or eGFR. Seventeen guidance documents provide a cut-off below which metformin should not be used (nothing or all). The more logical recommendation to adapt the dose of metformin according to renal function, as is done for other drugs excreted by the kidneys, only appeared in eight guidance documents.

The guideline development group explicitly wanted to highlight this important change in paradigm to adapt the dose to renal function rather than to stop metformin.

With regard to glitazones, the guideline development group preferred not to make an official statement, as these drugs are currently under regulatory scrutiny and are no longer available on most markets. A major concern of the guideline development group was that not all information may be publicly available, and that, by lack of access to all information, an incorrect statement would be made.

We recommend adding on a drug with a low risk for hypoglycaemia (Figs. 5, 6 and 7) as additional agent when improvement of glycaemic control is deemed appropriate according to Figure 4 (18).

One should carefully weigh the expected benefits and drawbacks before upgrading glycaemia-lowering therapy in our target population of patients with type 2 diabetes and CKD stage 3b or higher (eGFR <45 mL/min), as there is no clear expected advantage in terms of mortality, and there might be an increased risk for adverse effects, such as hypoglycaemia and weight gain.

When cost is an issue, a short-acting second-generation sulphonylurea with no active metabolites could be considered, as these drugs are commonly cheaper than other glycaemia-lowering drugs. However, one should take into account that a reduction of the glycaemia-lowering effect of sulphonylurea over time is common, due to islet cell exhaustion. Many of these drugs require progressive dose reduction with progression of CKD, and some are contra-indicated in CKD stage 5, as depicted in Figure 6 [110]. Glipizide, repaglinide, and glibidone, however, do not require specific dose reduction. In dialysis patients, the glitunides should generally be avoided.

In other cases, if improvement of glycaemic control is considered of benefit, adding a GLP-1 agonist rather than insulin to metformin might offer the advantages of lower risk for hypoglycaemia and better control of body weight [113]. However, the guideline group wants to point out that CKD patients appear to have a normal incretin production, but a reduced incretin effect, suggesting a reduced β-cell response to incretin in CKD [114]. A well-performed study with GLP1 agonists in patients with diabetes and renal insufficiency would be needed to provide evidence for the role of GLP1 agonists in this population. Liraglutide is highly protein bound, is not eliminated through a kidney-mediated pathway and only a small fraction of its metabolites are recovered in urine [115]. From a pharmacokinetic or pharmacodynamic perspective, the drug should thus be considered as safe in patients with renal insufficiency, even at advanced stages. Exenatide is cleared by proteolytic activity after glomerular filtration, and its clearance is therefore strongly diminished in patients with impaired renal function. As a consequence, its use is not recommended in CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) [110]. Pancreatitis is a rare complication of GLP-1 agonists [116].

Beneficial effects of DPP-4 inhibitors have only been documented for surrogate markers, and data on hard endpoints such as all-cause mortality, or cardiovascular, macrovascular and microvascular events are scarce [113]. A recent large RCT demonstrated no improvement in cardiovascular outcomes in patients receiving saxagliptin versus placebo as add-on therapy, and with an increased risk for hospitalization for congestive heart failure [92]. As a consequence, the guideline group judges that adding a DPP4-I to metformin seems to be safe in terms of hypoglycaemia risk, and does not result in an increase of weight [117–119], but on the other hand, the expected benefit in terms of hard endpoints is low. Sitagliptin, vildagliptin, alogliptin and saxagliptin all require dose reduction in CKD, whereas linagliptin does not [110]. Whereas some guideline group members consider renal clearance of a drug a disadvantage, others argued that in this way a lower dosing (and thus cost reduction) can be achieved.

Of note, these drugs are often marketed in combination pills with metformin in one formulation. The guideline development group wants to draw attention to the fact that these formulations should be avoided in patients with CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), as the two components have different dose adaptation requirements.
Although gastrointestinal tolerance might be problematic, adding an α-glucosidase inhibitor as second-line therapy to metformin might be considered, as the risk of hypoglycaemia is very low [120, 121], and they result in a modest weight decrease [122, 123]. However, also here, data on patient-relevant outcomes such as all-cause mortality or cardiovascular effects are largely lacking.

Triple therapy further increases the risk for hypoglycaemia [124], especially when insulin rather than another oral glycaemia-lowering agent was added as a third agent [125]. When administered to patients with insufficient glycaemic control under metformin and a sulphonylurea, both biphasic insulin and bolus insulin were associated with weight gain, whereas DPP-4 inhibitors and α-glucosidase inhibitors were weight-neutral, and GLP-1 analogues were associated with modest weight loss [124, 125].

We recommend instructing patients to temporarily withdraw metformin in conditions of pending dehydration, when undergoing contrast media investigations, or when there is a risk for AKI (1C).

As it is unclear whether metformin per se is associated with an enhanced risk for lactic acidosis [108, 109], the guideline development group judges that using metformin in doses adapted to GFR in stable CKD is safer than switching to other glycaemia-lowering drugs such as insulin, which might increase the risk of hypoglycaemia.

However, there is indirect evidence that a rapid drop of GFR can lead to a sudden accumulation of metformin. Therefore, patients should be instructed to reduce or stop metformin in conditions with enhanced risk of acute kidney injury, e.g. severe bouts of diarrhoea, or dehydration or fever. The guideline development group feels that this patient information is an essential part of good clinical management in this regard, and therefore recommends providing a patient information card/leaflet that should be handed over to patients with CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) on metformin.

• What do the other guidelines say?

No other guidelines provide specific recommendations on this topic for our patient population.

Suggestions for future research
1. Ideally, glycaemia-lowering drugs should be investigated and compared for their effects on hard endpoints, e.g. cardiovascular disease, death, micro- and macrovascular complications, QoL and risk for severe hypoglycaemia, and this in patients with diabetes and CKD stage 3b–5.
2. A study as described under (1) should be done specifically for metformin. This study should not only assess hard endpoints, as described in (1), but also clarify whether it is useful to monitor plasma metformin levels on a regular basis.

9. CHAPTER 3. ISSUES RELATED TO MANAGEMENT OF CARDIOVASCULAR RISK IN PATIENTS WITH DIABETES AND CKD STAGE 3B OR HIGHER

Chapter 3.1

In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) or on dialysis and with CAD, is percutaneous coronary intervention (PCI), coronary artery bypass grafting (CABG) or conservative treatment to be preferred?

Statements
3.1.1 We recommend not omitting coronary angiography with the sole intention of avoiding potential contrast-related deterioration of kidney function in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) in whom a coronary angiography is indicated (1D).
3.1.2 We recommend that optimal medical treatment should be considered as preferred treatment in patients with diabetes and CKD stage 3b–5 who have stable CAD, unless there are large areas of ischaemia or significant left main or proximal LAD lesions (1C).
3.1.3 We recommend that when a decision is taken to consider revascularization, CABG is preferred over PCI in patients with multivessel or complex (SYNTAX score >22) CAD (1C).
3.1.4 We recommend that patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) who present with an acute coronary event should be treated no differently than patients with CKD stage 3b or higher (eGFR <45 mL/min) without diabetes or patients with diabetes without CKD stage 3b or higher (eGFR <45 mL/min) (1D).

Advice for clinical practice:
* For patients with stable CAD,
  * Optimal medical treatment is the preferred treatment.
  * When there are large areas of ischaemia, or indications of significant left main or proximal LAD lesions, elective CABG is the preferred treatment.

* For patients presenting with ST-elevation myocardial infarction (STEMI), primary PCI is recommended over fibrinolysis if it can be performed within the recommended time limits.

* For patients presenting with non-STEMI (NSTEMI)
  * CABG results in improved outcomes (mortality, MACE) when compared with PCI when they have main stem lesions and/or advanced multivessel disease.
  * Pharmacological treatment, including anti-thrombotic therapy, has a place provided the doses of the medications are adapted to renal function.
Rationale

Why this question?

CKD and diabetes are two of the most important risk factors for poor outcomes in patients with CAD, but it is unknown whether the combination of CKD stage 3b or higher (eGFR <45 mL/min) and diabetes influences the efficacy of treatment strategies of CAD. PCI or CABG may improve the major outcomes and survival but also increase the risk of specific complications, such as bleeding and further deterioration of renal function and infections. The question investigates whether maintaining conservative medical therapy or promoting potentially aggressive interventions (either PCI or CABG) would help to improve survival in this specific population.

What did we find?

Both diabetes and CKD are associated with a poorer prognosis in patients with acute and stable CAD [126–129]. In large registry cohorts, these conditions are also associated with less and delayed diagnostic and therapeutic interventions [130].

In general, three different clinical scenarios can be considered for patients with diabetes and CKD stage 3b–5 who have CAD: patients with stable CAD, patients with STEMI and patients with NSTEMI.

The guidelines of the European Society of Cardiology (ESC) describe extensively the different treatment options in general for patients with stable CAD, STEMI and NSTE-MI [131]. Specific ESC guidelines have also been developed for patients with diabetes [132] but not for patients with CKD stage 3b or higher or the combination of both.

Specific randomized clinical trials for the treatment of CAD in patients with diabetes are scarce, and for patients with CKD stage 3b or higher or the combination of diabetes and CKD stage 3b or higher, we did not find any RCTs. For this specific patient group, only very limited, indirect evidence from subgroup analyses from RCTs in the general population or from real-life observational registries is currently available. Therefore, very specific recommendations for treatment of CAD in these patients are difficult to formulate. For this chapter, the currently available evidence is summarized, starting from the ESC guidelines. We did an additional systematic search on available studies (Supplementary data table in Chapter 3.1).

Patients with stable CAD. The ESC guideline on management of cardiovascular disease in patients with diabetes [132] recommends that optimal medical treatment should be considered as preferred treatment in patients with stable CAD and diabetes, unless there are large areas of ischaemia or significant left main or proximal LAD lesions. This recommendation was largely based on the BARI 2D trial [133]. In this trial, however, patients with a creatinine level >2 mg/dL (>177 μmol/L) were excluded as well as patients who required immediate revascularization or had left main CAD disease, class III-IV heart failure patients and patients who had undergone PCI or CABG within the previous 12 months.

When a decision is taken to consider revascularization, the ESC guidelines recommended CABG to PCI in patients with multi-vessel or complex (SYNTAX score >22) CAD, as this improved survival free from major cardiovascular events (subgroup analyses of the BARI 2D [133], SYNTAX [134], FREEDOM [135] trial and recent larger registries and meta-analyses [136–139]). PCI for symptom control may be considered as an alternative to CABG in patients with diabetes and less complex multi-vessel CAD (SYNTAX score ≤22) in need of revascularization.

In a post hoc analysis of the COURAGE study [140] with 2287 patients with stable CAD, patients with and without CKD were randomized to PCI and optimal medical therapy (OMT) or OMT alone. After adjustment for differences, the study showed that PCI did not reduce the risk of death or myocardial infarction when added to OMT [141]. Available data from registries suggest a trend towards better long-term survival with CABG when compared with PCI in patients with CKD stage 3b or higher. In patients with CKD stage 3b or higher, but not yet dialysis-dependent, CABG is associated with a higher procedural mortality and a greater likelihood of need for dialysis after revascularization.

Patients with STEMI

In patients with diabetes who present with STEMI, primary PCI is recommended over fibrinolysis, if available, and should be performed within recommended time limits [142]. As a consequence of the higher absolute risk, the number needed to treat (NNT) to save one life at 30 days was significantly lower for diabetes patients (NNT 17; 95% CI 11–28) than for non-diabetes patients (NNT 48; 95% CI 37–60). As it is the case for patients without diabetes, a subgroup analysis of patients with diabetes in the occluded artery trial [143] showed no benefit of revascularization of an occluded infarct-related artery 3–28 days after myocardial infarction. In patients with milder degrees of CKD, results from registries suggest that primary PCI is associated with a better outcome, but this finding is uncertain for those with CKD stage 3b–5 or on dialysis.

Patients with NSTEMI. Patients with diabetes have a high risk for mortality and an unfavourable course, and as such require aggressive pharmacological as well as early invasive (EI) management when presenting with NSTEMI. In the case of main stem lesions and/or advanced multi-vessel disease, CABG should be favoured over PCI, although most of the data supporting this recommendation come from studies with diabetes patients who have stable CAD, and it is unclear whether these data can be extrapolated to patients with NSTEMI. Patients with NSTEMI and CKD stage 3b–5 should receive the same first-line antithrombotic treatment as patients without CKD stage 3b–5, unless they have main stem lesions and or/advanced multi-vessel disease on coronaryography. Appropriate dose adjustments according to the severity of renal dysfunction should be made. It is unclear, however, whether an invasive strategy has an impact on clinical endpoints in these patients, as most trials of revascularization in NSTEMI excluded patients with more advanced stages of CKD. In general, ESC guidelines on NSTEMI state that CABG or PCI is recommended in
patients with CKD amenable to revascularization after careful assessment of the risk-benefit ratio in relation to the severity of renal dysfunction. Data from registries and observational studies suggest that an EI therapy is associated with a better outcome in earlier stages of CKD, but the benefit decreases with worsening renal function and is uncertain in those with CKD stage 3b–5 or on dialysis. Data from the Korean Registry Study [144] with 5185 patients in total, compared EI, deferred invasive (DI) and conservative strategies in patients with acute NSTEMI and CKD. At 1-year follow-up, mortality rates in the conservative group were significantly higher than in the invasive groups except for the severe CKD group. The benefit of the early over the delayed intervention strategy tended to decrease as renal function decreased. Data presented by the USRDS registry in a 2002 [145] report showed that in diabetic ESRD, there was no significant difference in all-cause death risk for stent intervention (RR 0.99; 95% CI 0.91–1.08) but a 19% reduction for CABG surgery (RR 0.81; 95% CI 0.75–0.88) compared with PTCA. In patients with diabetes and on dialysis, there was also no significant reduction in cardiac death risk for stent intervention (RR 0.99; 95% CI 0.89–1.11) compared with PTCA alone. In contrast, the risk for cardiac death in patients with diabetes undergoing dialysis was 27% lower after CABG surgery (RR 0.73; 95% CI 0.66–0.81) compared with PTCA.

More recently, a 2012 USRDS report [146] showed that in dialysis patients, CABG when compared with PCI is associated with significantly lower risks of both death (HR 0.87; 95% CI 0.84–0.90) and the composite of death and myocardial infarction (HR 0.88; 95% CI 0.86–0.91). Subgroup analysis showed no evidence that age, race, diabetes, duration of ESRD, MI on index presentation, dialysis modality, stent era, or index year significantly modified the association of CABG and PCI on death.

Similar results were obtained after the release of the FREE-DOM trial [135] results, a randomized trial that enrolled 1900 patients with diabetes and multi-vessel CAD to undergo either PCI with drug-eluting stents or CABG. For patients with diabetes and advanced CAD, CABG was superior to PCI in that it significantly reduced rates of death and myocardial infarction but was associated with a higher rate of stroke. A subgroup analysis of 129 patients with CKD showed that CABG when compared with PCI resulted in a non-significant reduction of the primary composite outcome of mortality, non-fatal MI or non-fatal stroke. However, the greater benefit of CABG versus PCI was consistent across all prespecified subgroups.

A very recent meta-analysis including patients with diabetes in general demonstrated a beneficial effect for CABG over PCI [147].

What do the other guidelines say?

Guidance in this section is largely based on the ESC guidelines. The KH-CARI guideline on management of cardiovascular risk in CKD recommends that, in patients with CKD, end-stage renal failure and after kidney transplantation, guidelines for revascularization of the general population should be adhered to (1D).

None of the other nephrology guidelines provide guidance in this area.

Suggestions for future research. A RCT of conservative versus PCI versus CABG in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) who present either with stable CAD or non-STEMI to investigate hard outcomes such as mortality, ESRD, QoL.

Chapter 3.2

In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) or on dialysis and with a cardiac indication (heart failure, ischaemic heart disease, hypertension) should we prescribe inhibitors of the RAAS system as cardiovascular prevention?

Statements

3.2.1 We recommend that adults with CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) or on dialysis and who have a cardiovascular indication (heart failure, ischaemic heart disease) be treated with an ACE-I at maximally tolerated dose (1B).

3.2.2 We suggest there is insufficient evidence to justify the start of an angiotensin-receptor blocker (ARB) in adults with CKD stage 3b or higher (eGFR <45 mL/min/1.73 m² or on dialysis) and diabetes who have a cardiovascular indication (heart failure, ischaemic heart disease) but intolerance for ACE-I (2B).

3.2.3 We recommend not combining different classes of renin angiotensin-blocking agents (ACE-1, ARBs or direct renin inhibitors) (1A).

Advice for clinical practice. There is insufficient evidence whether or not RAAS inhibitors should be stopped in patients with CKD progressing to CKD stage 5. A trial stopping the RAAS inhibitor with the aim to delay the need to start renal replacement therapy can be discussed with the patient.

Rationale

• Why this question?

In patients with CKD stage 3–5, death is a more likely outcome than progression to ESRD. Diabetes is a multiplier of CVD risk. Therefore, in this particular population, drugs that would slow progression of renal disease and at the same time be cardioprotective appear as a theoretical ‘first-line’ therapy. Blockers of the RAAS system are both renoprotective and cardioprotective in the general population. However, in patients with diabetes and CKD stage 3b or higher, this potential benefit may be more limited or be counterbalanced by the need to start dialysis earlier (e.g. because of hyperkalaemia, or sudden deterioration of renal function). It can thus be questioned whether, in this specific subpopulation, starting an RAAS blocker in patients who have a cardiac indication, is justified.
As many patients will already be on these drugs before they develop CKD stage 3b or higher, the question should also be asked whether withdrawing these drugs is justified.

This question does not handle patients who only have a renal indication (proteinuria) or hypertension.

- What did we find?

**Effects on cardiovascular endpoints and mortality.** We found nine RCTs and two post hoc analyses examining the outcomes after using inhibitors of the RAAS system or aldosterone receptor antagonists as cardiovascular prevention in patients with CKD (eGFR <60 mL/min/1.73 m² or on dialysis) and diabetes and with a cardiovascular indication (heart failure, ischaemic heart disease, vascular disease) [148-159]. Unfortunately, none of these studies data were presented by categories of patients according to staging of CKD, making it impossible to make a statement specifically about inhibitors of the RAAS system or aldosterone receptor antagonists in the eGFR <45 mL/min/1.73 m² or on dialysis category. Results varied widely between studies (see Supplementary data). For the major end-point of mortality, the overall analysis shows no difference between intervention and controls, with a hazard ratio ranging from 0.64 to 1.05 (four studies in favour of RAAS inhibition, three studies contra, with comparable populations). A pooled analysis of the included studies showed a favourable trend for RAAS-blocking agents. They also reduce by 10% non-fatal CV events in populations including both patients with and without diabetes. The dichotomous composite outcome assessing CKD progression (need for RRT or doubling of serum creatinine), showed a 22% difference in favour of RAAS-blocking agents for patients with diabetes (moderate quality of evidence).

No effect on a composite outcome of cardiovascular death, non-fatal myocardial infarction or stroke (289/1719 versus 299/1675, RR 0.91, 95% CI 0.76–1.09 in the pooled analysis of the subgroup of patients with diabetes) was observed in a systematic review [160] including atherosclerotic normotensive (systolic RR <130 mmHg) patients. Only patients treated with maximally tolerated doses of ACE-I versus placebo, had a survival benefit (RR 0.78, 95% CI 0.61–0.98), but not those treated at lower doses of ACE-I (RR1.18, 95% CI 0.41–3.44) or with ARBs (RR 0.99, 95% CI 0.85–1.17) in a Cochrane review [161].

The TRANSCEND [162] (Telmisartan Randomized Assessment Study in ACE Intolerant Subjects with Cardiovascular Disease, n = 5927 patients) compared telmisartan with placebo in patients at high vascular risk and intolerant for ACE inhibitors (ACE-I). Telmisartan had no effect on the primary cardiovascular outcome (15.7% versus 17.0%; HR 0.92; 95% CI 0.81–1.05) nor on the secondary outcomes—a composite of cardiovascular death, myocardial infarction or stroke (13.0% versus 14.8%; HR 0.87; 95% CI 0.76–1.00, but P = 0.068 after adjustment for multiplicity of comparisons and overlap with primary outcome). In a post hoc analyses of the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) [153] (n = 33 357), treatment with a calcium channel blocker, ACE-I or a diuretic was compared in high-risk hypertensive patients with a reduced GFR for a composite end-point including ESRD, 50% or greater decline in GFR, or death from any cause. The RRs for patients taking amldipine compared with those taking chlorthalidone for this endpoint was 1.02 (95% CI 0.90–1.15; P = 0.78) and lisinopril compared with chlorthalidone was 1.02 (95% CI 0.90–1.15; P = 0.80) in a GFR of <60 mL/min per 1.73 m² stratum. Estimated GFRs were similar between participants assigned to receive lisinopril and chlorthalidone at years 1, 2, 4 and 6. This pattern was consistent for participants with diabetes and when stratified by baseline GFR. In an RCT [157] (n = 1513) comparing losartan (50 to 100 mg once daily) to placebo, both taken in addition to conventional antihypertensive treatment (calcium-channel antagonists, diuretics, alpha blockers, beta blockers and centrally acting agents), for a mean of 3.4 years, a total of 327 patients in the losartan group versus 359 in the placebo group reached the primary endpoint (risk reduction 16%, P = 0.02). Losartan reduced the incidence of a doubling of the serum creatinine concentration (risk reduction, 25%; P = 0.006) and end-stage renal disease (risk reduction 28%; P = 0.002) but had no effect on the rate of death. The reductions in the risk of end-stage renal disease and end-stage renal disease or death changed little after correction for blood pressure (26%, P = 0.007, and 19%, P = 0.02, respectively). In the ONTARGET [159] study, of 17 118 patients, 6982 had diabetes, and no interaction of diabetes versus non-diabetes was observed. There was no difference in mortality in the overall group between ramipril or telmisartan, but there was a higher mortality in the group randomized to the combination therapy (HR combination versus ramipril: HR 1.07, 95% CI 0.98–1.17).

**Renal outcomes.** For the composite renal outcome of dialysis or doubling of serum creatinine, the effects of telmisartan in the TRANSCEND trial [162] varied according to the baseline urinary albumin creatinine ratio (P = 0.006 for interaction) and estimated GFR (P = 0.022). Telmisartan increased the incidence of the composite renal outcome in patients with no microalbuminuria or an estimated GFR greater than 60 mL/min per 1.73 m². In contrast, telmisartan tended to reduce this outcome in those with microalbuminuria or an estimated GFR <60 mL/min/1.73 m². Treatment with RAAS inhibitors was associated with slower progression to ESRD [150, 152, 156–158] as defined by doubling of the serum creatinine concentration or renal replacement therapy, the hazard ratio ranging from 0.67 to 1.29 in the included studies. In the ONTARGET [159] study, of 17 118 patients, 6982 were patients with diabetes. There was no interaction of diabetes versus no diabetes. Whereas there was no difference between ramipril and telmisartan in the endpoints acute dialysis, chronic dialysis or doubling of serum creatinine (HR 1.09; 95% CI 0.89–1.34), the combination group had a higher risk versus the ramipril alone group (HR 1.24; 95% CI 1.01–1.51). In a meta-analysis by Casas et al. [163], a subgroup analysis for patients with diabetes (34 studies, 4772 patients, no further segregation for baseline renal function or albuminuria), the use of ACE-I or ARB was associated with a reduction in albuminuria (mean difference −12. 21, 95% CI −21.68 to −2.74 mg/day), but had no impact on GFR (−1.19, 95% CI −2.69 to +0.31 μL/min). The authors conclude that claims that ACE-I and ARBs are renoprotective in diabetes seem to derive from small placebo-controlled trials, and any...
true advantage over and above blood pressure control is uncertain.

In a Cochrane review [161] of general patients with diabetes, there was a significant reduction in the risk of ESRD with ACE-I compared with placebo/no treatment (10 studies, 6819 patients, RR 0.60, 95% CI 0.39–0.93) and with ARBs compared with placebo/no treatment (3 studies, 3251 patients, RR 0.78, 95% CI 0.67 to 0.91). There was some evidence of a reduction of the risk of doubling of serum creatinine concentration with ACE-I compared with placebo/no treatment (9 studies, 6780 patients, RR 0.68, 95% CI 0.47–1.00) and with angiotensin-receptor antagonists compared with placebo/no treatment (3 studies, 3251 patients, RR 0.79, 95% CI 0.67 to 0.93). ACE-Is and ARBs significantly reduced the risk of progression from micro- to macroalbuminuria (17 studies, 2036 patients, RR 0.45, 95% CI 0.29–0.69 and 3 studies, 761 patients, RR 0.49, 95% CI 0.32–0.75, respectively). In this systematic review, no separate analysis was done for patients with diabetes and advanced CKD stage 3b or higher. However, the stage of nephropathy in enrolled populations (microalbuminuria versus macroalbuminuria or mixed populations with micro- or macroalbuminuria) did not significantly affect any of the reported outcomes.

The ONTARGET trial, described in the preceding section, evaluated ramipril, telmisartan and combination therapy in over 25,000 patients at high risk for cardiovascular events. Combined therapy with ramipril alone was associated with significant increases in hypotensive symptoms (4.8% versus 1.7%), syncope (0.3% versus 0.2%) and renal dysfunction (1.1% versus 0.7%) [159]. There was also a significant increase in hyperkalaemia, defined as a serum potassium above 5.5 mEq/L (5.7% versus 3.3%) and an almost significant increase in overall mortality (12.5% versus 11.8% with ramipril alone, risk ratio 1.07, 95% CI 0.98–1.16).

An increased incidence of adverse events with combination therapy was also demonstrated in a meta-analysis of four randomized trials that compared 17,337 patients with chronic heart failure who received either an ACE-I alone or the combination of an ACE-I and an ARB [164].

Compared with patients who received an ACE-I alone, those treated with both agents had significantly higher rates of the following complications: increased medication discontinuation due to adverse effects (15% versus 11%); worsening renal function, defined as an increase in creatinine of 0.5 mg/dL (44.2 μmol/L) or more over baseline (3.3% versus 1.5%); hyperkalaemia (3.5% versus 0.7%) and symptomatic hypotension (2.4% versus 1.5%).

No studies on the effects of aldosterone receptor antagonists in this subpopulation were retrieved.

- How did we translate the evidence into the statement?

We recommend that adults with CKD stage 3b or higher (eGFR <45 mL/min/1.73 m² or on dialysis) and diabetes who have a cardiovascular indication (heart failure, ischaemic heart disease) be treated with an ACE-I at maximally tolerated dose (1B).

The data seem to be consistent with an improved overall mortality and reduced cardiovascular events in patients with diabetes treated with ACE-Is. Therefore, the guideline development group believes that the use of these drugs can be justified in patients with a cardiac indication for RAAS blockade, as the risk of death is, in patients with diabetes with CKD stage 3b or higher (eGFR <45 mL/min), higher than that of progression to ESRD.

We suggest there is insufficient evidence to justify the start of an ARB in adults with CKD stage 3b or higher (eGFR <45 mL/min/1.73 m² or on dialysis) and diabetes who have a cardiovascular indication (heart failure, ischaemic heart disease) but intolerance for ACE-I (2B).

For ARBs, the protective effect on mortality and cardiovascular events is less clear, and, according to the TRANSCEND trial, switching to an ARB in patients intolerant for ACE-Is, does not improve outcome. Recent data [165], not included in our data extraction as they appeared after our official search dates, indicate that brachial blood pressure decreased as well without any significant difference between placebo and irbesartan. Intermediate cardiovascular endpoints such as central aortic blood pressure, carotid-femoral pulse-wave velocity, left ventricular mass index, N-terminal brain natriuretic hormone, heart rate variability and plasma catecholamines were not significantly affected by irbesartan versus placebo treatment. Changes in systolic blood pressure (SBP) during the study period significantly correlated with changes in both left ventricular mass and arterial stiffness. Thus, significant effects of irbesartan on intermediate cardiovascular endpoints beyond blood pressure reduction were absent in HD patients.

Recent meta-analyses in the overall diabetes population [166] and in patients with hypertension [167] come to comparable conclusions.

The present data on withdrawing RAAS inhibitors in patients already taking them for a cardiac indication when their CKD progresses to an eGFR <30 mL/min/1.73 m² are controversial, and no randomized trials on this intervention are available. However, observational data, even in patients without diabetes, suggest that in patients with an eGFR <30 mL/min, the risk for hyperkalaemia is 6.8 (95% CI 2.7–17.4) times higher than in patients with an eGFR >50 mL/min [168]. In an observational study of 52 patients (46% with diabetes), Ahmed et al. [169] report an increase in eGFR from 16.38 ± 1 mL/min/1.73 m² at inclusion to 26.6 ± 2.2 mL/min/1.73 m² (P = 0.0001) after 12 months.

The guideline development group judges that it thus makes sense to discuss the withdrawal of an RAAS inhibitor with patients whose eGFR progresses to <15 mL/min, in an attempt to delay the need for start of renal replacement therapy.

We recommend not combining different classes of renin angiotensin blocking agents (ACE-I, ARBs or direct renin inhibitors) (1A).
This statement is mainly based on a large RCT demonstrating no beneficial effect, and increased side effects in patients randomized to a combination therapy of ramipril and telmisartan[159]. In this study, an interaction analysis was performed for presence of diabetes, showing no arguments that the interpretation of the results should be different in patients with diabetes.

- What do other guidelines say?
  The KH-CARI guideline on management of cardiovascular risk in CKD from 2013 suggests that ACEi or ARBs should be used in most people with CKD who require blood pressure lowering (particularly those with albuminuria), due to the volume of evidence showing benefits for cardiovascular as well as renal outcomes (2B), but that diuretics, calcium channel blockers and beta blockers may also be used to lower blood pressure in people with CKD requiring treatment (2B). KH-CARI further recommends that a combination of two or more renin angiotensin-blocking agents, ACE-Is, ARBs or direct renin inhibitors, should not be used to prevent cardiovascular or renal events in people with CKD, as the combination provides no additional proven benefit while increasing the risk of adverse outcomes (1B).

- Suggestions for future research?
  An RCT on the impact of withdrawing or maintaining of RAAS inhibitors in patients already taking them for a cardiac indication when their CKD progresses below different thresholds below eGFR <45 mL/min/1.73 m² on mortality, cardiovascular outcomes and evolution to ESRD.

Chapter 3.3.

In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) or on dialysis, should we prescribe beta blockers to prevent sudden cardiac death?

**Statements**

3.3.1 We suggest starting a selective beta-blocking agent as primary prevention in patients with diabetes and CKD stage 3b or higher and then continuing it when tolerated (2C).

3.3.2 We suggest prescribing lipophilic rather than hydrophilic beta-blocking agents in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) (2C).

**Rationale**

- Why this question?
  Sudden cardiac death is an important cause of mortality in patients with CKD stage 3b or higher and in patients with diabetes. Ventricular re-entrant circuits and fibrosis-ischaemia are likely to be part of this paradigm, together with electrolyte disturbances and other explanations.

It is appreciated that beta blockers can have an important role in several cardiac situations, e.g. ventricular rate control and heart failure. The question is whether or not the routine prescription of these drugs, with their known side effects, can provide a survival advantage in patients with diabetes with CKD stage 3b or higher (eGFR <45 mL/min).

- What did we find?
  We retrieved one systematic review [170] analysing the impact of different anti-hypertensive agents in patients with diabetes. No separate subgroup analysis of patients with CKD stage 3b or higher was provided, however. According to this systematic review, addition of a beta-blocking agent versus non-addition consistently improved survival (HR 7.13; 95% CI 1.37–41.39).

  Furthermore, we retrieved two multi-centred international RCTs [171, 172], one post hoc analysis [173] and four observational cohort studies [174–177] (two prospective [174, 175]). Most of these were at high risk of selection bias and bias by indication.

  In the Cardiac Insufficiency Bisoprolol Study (CIBIS) [173], 2647 patients with congestive heart failure (ejection fraction <35%) were randomized to different doses of bisoprolol or placebo. Patients on bisoprolol had a lower risk for hospitalization (0.80; 95% CI 0.71–0.91), reduced all-cause mortality (0.66; 95% CI 0.55–0.81) and sudden death (0.56; 95% CI 0.39–0.80). In an older RCT, use of beta-blocking agents when compared with enalapril in patients with congestive heart failure (ejection fraction <35%), resulted in comparable progression with end-stage renal disease [171].

- How did we translate the evidence into the statement? Which considerations were taken into account (GRADE)?
  There is no direct evidence that there is an interaction from diabetes or CKD stage 3b or higher (eGFR <45 mL/min) on the impact of the use of beta-blocking agents. We did not find any study reporting an increased harm or more side effects in patients with versus without diabetes.

  Although the CIBIS study [172, 173] focused on patients with congestive heart failure, and did not report an interaction for patients with diabetes and CKD stage 3b or higher, the guideline development group judges that congestive heart failure is quite prevalent in our target population, and that therefore, the results are very likely to also apply in our population.

  Based on these considerations, the guideline development group judged that it was logical to apply the same recommendations in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) as in patients with diabetes without CKD or in patients with CKD without diabetes [132].

**What do other guidelines say?**

We did not retrieve other guidelines providing advice on this topic for our target population.

**Suggestions for future research.** An RCT on the impact of beta-blocking agents on hard outcomes in patients with...
diabetes and CKD stage 3b or higher (eGFR <45 mL/min) without heart failure.

**Chapter 3.4**

In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we aim at lower blood pressure targets than in the general population?

**Statements**

3.4.1 We suggest against applying lower blood pressure targets in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) than in the general population (2C).

3.4.2 We suggest that in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) but without proteinuria, all blood pressure-lowering drugs can be used equally to lower blood pressure (2C).

**Advice for clinical practice**

- Blood pressure should be carefully titrated to a target <140 mmHg SBP, while monitoring tolerance and avoiding side effects.
- Patients with diabetes and CKD stage 3b or higher might suffer from autonomic dysfunction and are thus more prone to complications associated with sudden hypotension.
- A diastolic blood pressure that is too low can jeopardize coronary perfusion.
- Why this question?
  Recommended blood pressure targets in the general population have slightly increased to 140 mmHg systolic over the last years. There is a general perception that, in patients with diabetes and/or CKD, we should aim at lower blood pressure targets. However, it has not been established whether such lower targets in this subpopulation will result in reduced mortality, morbidity or slower progression of CKD.
- What did we find?
  We found one Cochrane review [178], focusing, however, on the diabetes population in general. This review searched for RCTs comparing people with diabetes randomized to lower (<130/85 mmHg) or to standard (140–160/100 mmHg) BP targets and providing data on the following primary outcomes: total mortality, total serious adverse events, myocardial infarction, stroke, congestive heart failure and end-stage renal disease. As secondary outcomes, achieved mean systolic and diastolic BP and withdrawals due to adverse effects were registered.
  This Cochrane review [178] identified five randomized trials [179–183] (7314 participants, mean follow-up 4.5 years). Despite achieving a significantly lower BP (119.3/64.4 mmHg versus 133.5/70.5 mmHg, P <0.0001), the only benefit in the ‘lower’ SBP group was a reduction in the incidence of stroke: relative risk (RR) 0.58, 95% CI 0.39 to 0.88, absolute risk reduction 1.1%. There was no effect on mortality (RR 1.05; CI 0.84–1.30, low-quality evidence), but there was an increase in the number of serious adverse events (RR 2.58; 95% CI 1.70–3.91, absolute risk increase 2.0%).
  Four trials (total n = 2580) [179–183] specifically compared clinical outcomes associated with ‘lower’ versus ‘standard’ targets for diastolic blood pressure in people with diabetes. Despite a lower achieved blood pressure in the group assigned to the ‘lower’ diastolic blood pressure target (128/76 versus 135/83 mmHg, P <0.0001), there was no reduction in total mortality (RR 0.73; 95% CI 0.53–1.01), stroke (RR 0.67; 95% CI 0.42–1.05), myocardial infarction (RR 0.95; 95% CI 0.64–1.40) or congestive heart failure (RR 1.06; 95% CI 0.58–1.92) (all low-quality evidence due to high risk of selection bias). End-stage renal failure and total serious adverse events were not reported in any of the trials. A sensitivity analysis of trials comparing diastolic blood pressure targets <80 mmHg (as suggested in clinical guidelines) versus <90 mmHg showed similar results.
- How did we translate the evidence into the statement?
  The guideline development group judged that, based on these data, there is insufficient evidence to support the notion that in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min), we should aim at lower blood pressure targets than in the general population. The guideline development group acknowledges that the evidence was not specifically collected in our target group, as no separate analysis was performed for the specific subgroup of patients with diabetes and CKD stage 3b or higher. However, the guideline development group judged that it is quite unlikely that the findings in this particular subgroup would be any different, in view of the fact that this patient group is more likely to suffer from side effects and less likely to benefit from a decrease in cardiovascular mortality and morbidity.
- What do other guidelines state?
  The recent KDIGO guideline on management of hypertension advocates that adults with diabetes and CKD not on dialysis and with a urine albumin excretion of <30 mg per 24 h whose office blood pressure is consistently >140 mmHg systolic or >90 mmHg diastolic be treated with blood pressure-lowering drugs to maintain a blood pressure that is consistently <140 mmHg systolic and <90 mmHg diastolic (1B). If urine albumin excretion is >30 mg per 24 h, these targets are 130 mmHg systolic or 80 mmHg diastolic (2D). However, it is clear from the rationale that this recommendation is mainly focused on patients with an eGFR >45 mL. The recommendation for elderly patients advocates that blood pressure treatment in elderly patients with CKD not on dialysis should be tailored by carefully considering age, comorbidities and other therapies, with gradual escalation of treatment and close attention to adverse events related to BP treatment, including electrolyte disorders, acute
deterioration in kidney function, orthostatic hypotension and drug side effects (not graded).

The KHA-CARI guideline on management of cardiovascular risk factors in CKD recommends that blood pressure targets in people with CKD should be determined on an individual basis taking into account a range of patient factors (1C) including baseline risk, albuminuria level, tolerability and starting blood pressure levels. They suggest that most people with CKD should be treated to similar targets as the general population, such that most blood pressure readings are <140/90 (2D). KHA-CARI suggests that most blood pressure readings should be <130/80 in individuals with CKD and macroalbuminuria (2B). KH-CARI also suggests that ACE-Is or ARBs should be used in most people with CKD who require blood pressure lowering (particularly those with albuminuria), due to the volume of evidence showing benefits for cardiovascular as well as renal outcomes (2B).

Diuretics, calcium channel blockers and beta-blocking agents may also be used to lower blood pressure in people with CKD requiring treatment (2B).

Chapter 3.5

In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) or on dialysis, should we prescribe lipid-lowering therapy in primary prevention?

Table 8. Dose recommendations of statins in patients with CKD stage 3b or higher (eGFR <45 mL/min). Adapted from Tonelli and Wanner [189].

<table>
<thead>
<tr>
<th>Statin</th>
<th>Maximum dose when eGFR &lt;45 mL/min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lovastatin</td>
<td>No data</td>
</tr>
<tr>
<td>Fluvastatin</td>
<td>80 mg</td>
</tr>
<tr>
<td>Atorvastatin</td>
<td>20 mg</td>
</tr>
<tr>
<td>Rosuvastatin</td>
<td>10 mg</td>
</tr>
<tr>
<td>Simvastatin/ezetimibe</td>
<td>20/10 mg</td>
</tr>
<tr>
<td>Pravastatin</td>
<td>40 mg</td>
</tr>
<tr>
<td>Simvastatin</td>
<td>40 mg</td>
</tr>
<tr>
<td>Pitavastatin</td>
<td>2 mg</td>
</tr>
</tbody>
</table>

### Rationale

- **Why this question?**

In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) the impact of lipid-lowering treatment on patient-important outcomes is still not completely clear. Patients with CKD have a higher burden of cardiovascular disease as compared with the general population, and patients with CKD stage 3b or higher suffering from diabetes are considered to be at highest risk. However, the risk profile of patients with diabetes with CKD stage 3b or higher appears to be different from other patient populations, with uraemia-specific risk factors and non-atherosclerotic cardiovascular disease (non-ASCVD) playing a major role. Furthermore, due to a high medication load in this patient group, treatment-related side effects are perceived to be more prevalent and more serious when compared with the general population. We therefore aim to provide evidence about the effect of lipid-lowering treatment in patients with diabetes with CKD stage 3b or higher.

- **What did we find?**

We retrieved three recent systematic reviews analysing the effect of lipid-lowering therapies in patients with CKD. Upadhyay et al. [184] retrieved 18 RCTs, 5 of which involved CKD populations and 13 were CKD subgroup analyses from trials in the general population. They concluded that lipid-lowering therapy with statins did not improve kidney outcomes but decreases the risk for cardiac mortality [pooled risk ratio (RR) from six trials, 0.82 (95% CI 0.74–0.91)], cardiovascular events (including revascularization) [pooled RR from 9 trials, 0.78 (95% CI 0.71–0.86)] and myocardial infarction [pooled RR from 9 trials, 0.74 (CI, 0.67–0.81)]. Although there was a significant benefit for all-cause mortality (RR0.91, 95% CI 0.83–0.99), the upper limit of the confidence interval was close to 1 and there was significant heterogeneity across the studies. No benefit was found for other cardiovascular outcomes. Rates of adverse events were not different between intervention and comparator groups. No separate analysis was provided for patients with CKD stage 5 or on dialysis. Palmer et al. [185] retrieved a total of eighty trials comprising 51 099 participants. These authors, in contrast to Upadhyay et al. [184], also included studies comparing statin therapy with no treatment. Treatment effects of statins varied with stages of CKD. Moderate-to-high-quality evidence indicated that
statins reduced all-cause mortality (RR 0.81; 95% CI, 0.74–0.88), cardiovascular mortality (RR 0.78; 95% CI 0.68–0.89), and cardiovascular events (RR 0.76; CI 0.73–0.80) in persons not receiving dialysis. In contrast, in patients on dialysis, moderate- to high-quality evidence indicated that statins had little or no effect on all-cause mortality (RR 0.96; 95% CI 0.88–1.04), cardiovascular mortality (RR 0.94; 95% CI 0.82–1.07) or cardiovascular events (RR 0.95; 95% CI 0.87–1.03). Effects of statins in kidney transplant recipients were uncertain. Concerning adverse events, statins had little or no effect on cancer, myalgia, liver function or withdrawal from treatment. However, adverse events were evaluated systematically in fewer than half of the trials. The results of both of these systematic reviews were heavily influenced by the data of the SHARP study [186].

Jun et al. [187] searched for prospective RCTs assessing the effects of fibrate therapy compared with placebo in people with CKD. This systematic review retrieved 10 studies including 16 869 participants. In patients with mild-to-moderate CKD [estimated GFR (eGFR) <60 mL/min/1.73 m²], fibrates improved surrogate markers, including total cholesterol [reduction of 0.32 mmol/L, P <0.05, triglyceride levels (reduction of 0.56 mmol/L, P = 0.03)] and high-density lipoprotein cholesterol (increase of 0.06 mmol/L, P <0.001) but not low-density lipoprotein cholesterol (reduction of 0.01 mmol/L, P = 0.83). In patients with type 2 diabetes, fibrates reduced the risk of albuminuria progression (RR 0.86; 95% CI 0.76–0.98). Serum creatinine was elevated by fibrate therapy (increase of 33 μmol/L, P <0.001), and estimated GFR was reduced (2.67 mL/min/1.73 m², P <0.01). There was no detectable effect on the risk of end-stage kidney disease (RR 0.85; 95% CI 0.49–1.49). In patients with an eGFR of 30–59.9 mL/min/1.73 m², fibrates reduced the risk of major cardiovascular events (RR 0.70; 95% CI 0.54–0.89) and cardiovascular death (RR 0.60; 95% CI 0.38–0.96) but not all-cause mortality. There were no clear safety concerns specific to people with CKD stage 3b. Data on effects and safety in CKD stage 4 and 5 are lacking.

• How did we translate the evidence into the statement? Which considerations were taken into account (GRADE)?

We suggest a statin be considered in patients with diabetes and CKD stage 5 (2C).

In most post hoc analyses of RCTs, patients with CKD stage 5 not on dialysis were analysed as part of a larger group of non-dialysis-dependent patients including those with earlier stages of CKD. In general, these analyses suggested a benefit of statins in non-dialysis-dependent CKD. The SHARP study included 1221 patients with CKD stage 5 not undergoing dialysis. In these patients, lipid-lowering treatment resulted in a non-significant 8% risk reduction of the primary endpoint of major vascular events.

We recommend against starting a statin in patients with diabetes in CKD stage 5D (1A).

The 4D Study [188] did not show a meaningful benefit in patients with diabetes undergoing dialysis (mean time on dialysis 8 months). There was a non-significant 8% risk reduction of the primary endpoint of CV death, non-fatal MI and stroke. Therefore, the guideline group judged that there is no general recommendation to initiate statins in dialysis-dependent patients with diabetes.

There was no consensus in the guideline development group on whether or not statins should be stopped in patients with diabetes with CKD stage 5D.

A substantial number of patients became dialysis dependent during the study period in the SHARP trial [186]. There are no data directly addressing the question of whether lipid-lowering treatment should be stopped after initiation of dialysis. The SHARP data are interpreted by some as meaning that starting lipid lowering before ESRD and continuing through ESRD is beneficial, while starting too late during ESRD is associated with an uncertain benefit.

We recommend starting a statin in patients with diabetes and CKD stage 3b and 4 (1B).
Fibrates were investigated mainly in patients with earlier stages of CKD up to and including CKD stage 3b. These studies show a benefit by reducing cardiovascular events. No recommendation can be made for patients with diabetes and CKD stages 4 or higher, as data for this population are lacking.

As the guideline development group decided to recommend a risk-based treatment strategy, follow-up evaluation of lipid levels once treatment has started is not considered to be useful. This is in line with judgements of other groups [189], especially as, for most statins, a maximal dose should be considered in patients with CKD stage 3b or higher (eGFR <45 mL/min) (see Table 8). One initial measurement to identify and treat potential secondary causes of hyperlipidaemia is, however, still recommended.

What do the other guidelines say?

No guideline specifically provides guidance for our target audience of patients with diabetes and CKD stage 3b–5.

The KDIGO guideline on lipid management in CKD recommends treatment with a statin in adults aged >50 years with an eGFR <60 mL/min/1.73 m² but not treated with chronic dialysis or kidney transplantation (GFR categories G3a–G5) (1A). In adults aged >50 years with CKD and eGFR >60 mL/min/1.73 m² (GFR categories G1–G2), they recommend treatment with a statin, but with a lower level of evidence (1B). 2.2: In adults aged 18–49 years with CKD but not treated with chronic dialysis or kidney transplantation, KDIGO recommends statin treatment in people with known coronary disease (myocardial infarction or coronary revascularization), diabetes mellitus, prior ischaemic stroke, or an estimated 10-year incidence of coronary death or nonfatal myocardial infarction >10% (2A). In adults with dialysis-dependent CKD, KDIGO advises against initiation of a statin (2A), but also recommends continuing it in those already on a statin (2C). Of note, as KDIGO recommends that all patients with CKD stage 3b–5 should be started on a statin, in real-life practice this would imply that all patients on renal replacement therapy would be on a statin. In fact, this is a point of discordance between ERBP and KDIGO guidance. Within the ERBP guideline development group, there was no consensus on the topic of whether or not to stop statin treatment when starting dialysis. As ERBP, KDIGO states that in adults with CKD (including those treated with chronic dialysis or kidney transplantation), follow-up measurement of lipid levels is not required for the majority of patients (not graded).

Suggestions for future research. Should lipid-lowering therapy be stopped in patients entering renal replacement therapy?

Chapter 3.6

A. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we recommend interventions aimed at increasing energy expenditure and physical activity?

B. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we recommend interventions aimed at reducing energy intake?

Statements

3.6.1 We suggest that patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) perform additional physical exercise at least three times 1/2 to 1 hour/week to reduce fat mass and improve QoL (2D).

3.6.2 We suggest that there is no evidence of harm when promoting an individualized regimen of increased physical exercise (2C).

3.6.3 When promoting weight loss in patients with diabetes and with overweight, we recommend supervision of this process by a dietician and to ensure that only fat mass is lost and malnutrition is avoided (1C).

Rationale

• Why this question?

Physical activity is promoted in patients with diabetes as a lifestyle change measure complementary to diet and drugs, with the intention to improve metabolism and preserve cardiovascular functionality. Promoting physical activities requires specific programmes and follow-up, which might have a substantial impact on resources. Therefore, in patients with diabetes and CKD stage 3b or higher (GFR <45 mL/min), it is crucial to ascertain whether interventions focused on increasing energy expenditure may influence survival, morbidity and other major outcomes, such as physical performance, QoL and depression.

Dietary advice plays a central role in the management of diabetes. Dietary advice can have an impact on the QoL of patients, especially when combined for different targets, such as in patients with diabetes and CKD. Organisation of dietary advice can have an impact on utilization of resources. Therefore, in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min), it is important to verify whether structured dietary plans favourably influence survival, morbidity and other outcomes such as weight control, proteinuria, adherence to treatment and insulin sensitivity, with respect to standard care without structured dietary advice, and this without jeopardizing overall nutritional status or QoL.

• What did we find?

The results of this systematic review are published as a separate document [190]. In brief, we retained 11 studies
We suggest that patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) perform additional physical exercise at least three times 1/2 to 1 hour/week to reduce fat mass and improve QoL (2D).

There is lack of evidence that energy control in patients with diabetes and CKD can improve patient-centred hard outcomes such as mortality, major cardiovascular events or hospitalizations. There is, however, enough evidence that promoting energy expenditure or reducing energy intake (particularly by lifestyle interventions) might be useful for improving glycaemic control, BMI, body composition, QoL and physical functioning. An improvement of all these factors might translate into better long-term outcomes, but future studies focusing on hard outcomes are needed. It is likely that the ‘dose’ of interventions to improve energy balance may have been inadequate in many of the studies, with relatively small increases in energy expenditure on exercise programmes and relatively small decreases in calorie intake in patients given dietary advice; if it were possible to persuade patients with diabetes and CKD to do enough exercise, for instance, more weight loss, improved fitness and better long-term outcomes would be expected.

We suggest that there is no evidence of harm when promoting increased physical exercise (2C).

Since there is also no evidence that these programmes may cause harm, it would be reasonable to recommend energy control in those patients who are likely to benefit the most, such as obese patients.

When promoting weight loss in patients with diabetes and with overweight, we recommend supervision of this process by a dietician and to ensure that only fat mass is lost and malnutrition is avoided (1C).

When introducing such measures in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min), we should provide professional advice and guidance to prevent malnutrition in this frail population.

What do the other guidelines say?

We did not retrieve a guideline providing guidance for this specific patient population. The diabetes guideline of NICE recommends provision of individualized and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition. The dietary advice should be provided in a form sensitive to the individual’s needs, culture and beliefs and should take into account the individual patient’s willingness to change and the effects on their QoL. NICE further recommends individualising recommendations for carbohydrate and alcohol intake and meal patterns. Reducing the risk of hypoglycaemia should be a particular aim for a person using insulin or an insulin secretagogue. There is no specific recommendation on exercise therapy.

Suggestions for future research. Large-scale studies of the effects of a combination of regular aerobic and/or resistance exercise and dietitian-supervised calorie restriction on the functional status, QoL, and survival of obese patients with diabetes and CKD are required.

Chapter 3.7

In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should antiplatelet therapy be recommended, regardless of the cardiovascular risk?

Statements

3.7.1 We recommend against adding glycoprotein IIb/IIIa inhibitors to standard care to reduce death, myocardial infarction, or need for coronary revascularization in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) and acute coronary syndromes (ACSs) or high-risk coronary artery intervention (1B).

3.7.2 We suggest not adding a thienopyridine or ticagrelor to standard care to reduce death, myocardial infarction, or need for coronary revascularization in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) and ACSs or high-risk coronary artery intervention unless there is no additional risk factor for bleeding (2B).
3.7.3 We recommend starting aspirin as secondary prevention, unless there is a contraindication, side effects or intolerance (1C).

3.7.4 We suggest starting aspirin as primary prevention only in patients without additional risk factors for major bleeding (2C).

Advice for clinical practice. Consider clopidogrel as an alternative for aspirin in patients with clear intolerance or contraindications for aspirin.

Rationale

Why this question?

In patients with diabetes and CKD stage 3b or higher (especially those on dialysis), it is important to clarify whether antiplatelet therapy should be prescribed in primary prevention. Some would argue that CKD patients have an enhanced cardiovascular risk, and based on that, should be placed on antiplatelet therapy in primary prevention. On the other hand, CKD patients might suffer from uraemic coagulopathy and may therefore be at a higher risk for major bleeding. In particular, in patients on HD, it is still debated whether antiplatelet therapy may improve the major outcomes and survival of vascular access or whether it may increase the risk of specific complications, such as bleeding or the need for transfusions.

What did we find?

We retrieved 303 records through database searching, 47 of which were assessed as full-text articles for eligibility. Finally, 12 studies were included for data extraction and quality assessment. Only two RCTs specifically handled this question [202, 203]. In addition, we found one meta-analysis including post hoc analyses, one systematic review by the Cochrane Collaboration [204, 205], one prospective cohort study [206], one case-control study [207], one quasi-RCT in patients with diabetes and CKD 1-2 [208] and one case series study [209].

Palmer et al. [204] analysed the impact of antiplatelet agents in CKD patients with stable or no cardiovascular disease and found uncertain effects on mortality. In this systematic review, nine trials (all post hoc subgroup analyses for patients with CKD, but not specific for patients with diabetes) involving 9969 persons, who had ACSs or were undergoing PCI, and 31 trials involving 11 701 persons with stable or no cardiovascular disease, were identified. Low-quality evidence was found indicating that in persons with diabetes and CKD stage 3b or higher (eGFR <45 mL/ min) presenting with ACSs, glycoprotein IIb/IIIa inhibitors or clopidogrel plus standard care compared with standard care alone had little or no effect on all-cause or cardiovascular mortality or on myocardial infarction but increased serious bleeding. Compared with placebo or no treatment in persons with stable or no cardiovascular disease, antiplatelet agents prevented myocardial infarction but had uncertain effects on mortality and increased minor bleeding according to generally low-quality evidence.

Dasgupta et al. (CHARISMA trial) reported an increased risk of death (overall and cardiovascular) in patients with type 2 diabetes with diabetic nephropathy on dual antiplatelet therapy (clopidogrel plus aspirin) when compared with aspirin alone [202]. This increase in mortality was not caused by a significant increase in bleeding risk, thus suggesting an independent effect.

The Japanese Primary Prevention of Atherosclerosis with Aspirin for Diabetes (JPAD) trial was a prospective, randomized, open-label trial conducted throughout Japan that enrolled 2539 type 2 diabetes patients without a history of atherosclerotic disease. Patients were assigned to aspirin versus placebo group (81 mg/day or 100 mg/day) and followed for a median of 4.37 years. In this subgroup analysis of JPAD, in Japanese patients with type 2 diabetes, low-dose aspirin therapy reduced the incidence of atherosclerotic events such as death from coronary or cerebrovascular causes in patients with a eGFR 60–89 mL/min/1.73 m², but not in those with eGFR <60 mL/min/1.73 m² [208]. In concordance with the mortality results, the JPAD trial did not demonstrate a benefit for myocardial infarction or stroke in patients with diabetes and eGFR <60 mL/min/1.73 m² [208]. McCullough et al. demonstrated a reduction of the in-hospital mortality rate in CKD patients with acute myocardial infarction treated with aspirin and beta-blocking agents as a secondary prevention [207]. However, in this study, few details on the subpopulation with diabetes were provided.

Wang et al. [205] studied the benefits and harms of PGE1 for preventing the progression of diabetic kidney disease. Based on the six small RCTs conducted in China, PGE1 may have a positive effect on reducing urinary albumin excretion, microalbuminuria and proteinuria in patients with diabetic kidney disease. None of the included studies reported the incidence of ESRD, all-cause mortality or QoL. These results should be interpreted with caution because of the poor methodological quality of the included studies and the small numbers of participants [205].

Prespecified subgroup data from the PLATO (Platelet Inhibition and Patient Outcomes) trial indicate that ticagrelor, an oral purinergic receptor inhibitor cleared by extra-renal mechanisms, reduces mortality and major cardiovascular events better than clopidogrel among patients with an eGFR <60 mL/min/1.73 m² and presenting with an ACS [212]. However, in previous studies analysing aspirin plus clopidogrel versus placebo, there was a trend for superior outcomes (all-cause and cardiovascular mortality) in the group receiving placebo. As such, the role of antiplatelet therapy in patients with CKD stage 3b or higher (eGFR <45 mL/min) remains uncertain.

Higher bleeding rates were observed in CKD patients with double or standard antiplatelet therapy [200, 204, 206]. The UK-HARP-I [213] trial, evaluating the safety of aspirin 100 mg daily versus placebo in CKD patients, found no increased risk for major bleeding (4/225 versus 6/223, P = NS), but a 3-fold higher risk of minor bleeding (34/225 versus 12./223, P = 0.001).

Evidence for efficacy and safety of aspirin in primary prevention is lacking or, at best, inconclusive, especially in the
subpopulation of patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min). We retrieved a systematic review [214], including three trials conducted specifically in patients with diabetes mellitus and six other trials in which such patients represent a subgroup within a broader population. Aspirin was found to be associated with a non-significant 9% decrease in the risk of coronary events (RR 0.91; 95% CI 0.79–1.05) and a non-significant 15% reduction in the risk of stroke (RR 0.85; 95% CI 0.66–1.11). There was significant heterogeneity between the studies for the estimated 10-year coronary event rates (2.5% to 33.5%).

• How did we translate the evidence into the statement? Which considerations were taken into account (GRADE)?

The important methodological pitfalls in the small studies on the use of antiplatelet therapy in patients with CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) and diabetes, regardless of their cardiovascular risk, hamper an evidence-based conclusion.

We recommend against adding glycoprotein IIb/IIIa inhibitors to standard care to reduce death, myocardial infarction or need for coronary revascularization in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) and acute coronary syndromes or high-risk coronary artery intervention (1B).

Taking into account the published data, we consider that there is only low-quality evidence to support adding glycoprotein IIb/IIIa inhibitors, thienopyridine or ticagrelor, to standard care. Indeed, despite a positive effect on myocardial infarction, the addition does not lead to a reduction of all-cause mortality, cardiovascular death, stroke or need for coronary revascularization in persons with CKD stage 3b or higher (eGFR <45 mL/min) and diabetes, but may result in an enhanced bleeding risk, which might even be substantial for glycoprotein IIb/IIIa inhibitors [215]. As such, the guideline development group judges that these latter agents do not have a place in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) with or without stable cardiovascular disease.

We suggest not adding a thienopyridine or ticagrelor to standard care to reduce death, myocardial infarction or need for coronary revascularization in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) and ACSs or high-risk coronary artery intervention unless there is no additional risk factor for bleeding (2B).

In the acute setting of a percutaneous intervention, there is a non-significant trend for improved all-cause mortality, cardiovascular mortality and need for coronary revascularisation, but there is substantial enhanced risk for bleeding in patients treated with platelet-inhibiting agents, especially for gastrointestinal bleeding [216]. When administered in the pre-operative phase before coronary artery bypass surgery, clopidogrel results in a higher risk of bleeding, and even a higher risk of death [217]. Ticagrelor was shown to be superior to clopidogrel in ACS patients with CKD (eGFR <60 mL/min) [212], but in this specific subgroup, clopidogrel itself was non-significantly worse when compared with placebo (CREDO, CURE) [218, 219]. The implications for the use of ticagrelor from these observations are unclear in the absence of a ticagrelor placebo-controlled trial.

Bleeding hazards and lack of clear efficacy in reducing cardiovascular morbidity and mortality need to be acknowledged when patients with CKD are being counselled about acute or long-term antiplatelet therapy [204].

We recommend starting aspirin as secondary prevention, unless there is a contraindication or side effects (1C).

The general recommendation to prescribe low-dose aspirin for secondary prevention is well established. There is no plausible reason why the impact of low-dose aspirin should be different in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min), unless there would be evidence for an enhanced bleeding risk. Based on the UK-HARP data, there is evidence that the use of aspirin does not increase the rate of major bleeding, although there is an enhanced risk for minor bleeding. Based on this indirect evidence, and in the absence of direct comparisons in our target population, the guideline development group suggests starting aspirin as secondary prevention, unless there is a contraindication or side effects.

We suggest starting aspirin as primary prevention only in patients without additional risk factors for bleeding (2C).

Data on the use of aspirin in primary prevention in our target population of patients with diabetes and CKD stage 3b–5 are scarce and show a non-significant trend for reduced incidence of coronary events and stroke. It was argued by some members of the guideline development group that CKD stage 3b–5 should be considered as a high cardiovascular risk, which justifies accepting this population as secondary prevention. In view of the evidence for a potential benefit for relevant outcomes, the high risk and the low economic cost of aspirin, the guideline group concluded that, in patients with diabetes and CKD stage 3b–5, use of aspirin can be considered unless there is a risk factor for bleeding or intolerance.

• What do the other guidelines say?

No guidelines focused specifically on this subpopulation of patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min). However, the Canadian guidelines (2011) studied the use of antiplatelet therapies in patients with CKD in general, and recommend aspirin, 75–162 mg daily, for primary prevention of ischaemic vascular events in patients with CKD stage 3b or higher (eGFR <45 mL/
min) and a low risk of bleeding. In addition, antiplatelet therapy should be considered for secondary prevention in patients with CKD and manifest vascular disease for which its benefits are established [220]. The American Diabetes Association guidelines from 2013 recommend considering aspirin therapy (75–162 mg/day) as a primary prevention strategy only in those with type 1 or type 2 diabetes at increased cardiovascular risk (10-year risk >10%). This includes most men aged >50 years or women aged >60 years who have at least one additional major risk factor (family history of CVD, hypertension, smoking, dyslipidaemia, or albuminuria), and probably also most patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min) [221].

NICE recommends in its guideline on the management of diabetes to offer the following: low-dose aspirin, 75 mg daily, to a person with diabetes who is 50 years old or over if blood pressure is below 145/90 mmHg; low-dose aspirin, 75 mg daily, to a person who is under 50 years of age and has significant cardiovascular risk factors (features of the metabolic syndrome, strong early family history of cardiovascular disease, smoking, hypertension, and from cardiovascular disease, microalbuminuria); clopidogrel instead of aspirin only in those with clear aspirin intolerance (except in the context of acute cardiovascular events and procedures).

**Suggestions for future research.** RCTs to examine the benefits and harms of using antiplatelet agents as primary prevention in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min).

**SUPPLEMENTARY DATA**

Supplementary data are available online at http://ndt.oxfordjournals.org.

**ACKNOWLEDGEMENTS**

We would like to express our sincerest gratitude to all internal reviewers for taking the time to critically read the drafts of this document and to provide us with their comments. We strongly believe this has contributed to the quality of the guideline and has helped maximize its practical value. Finally, we gratefully acknowledge the careful assessment of the draft guideline by external reviewers from the KHA-CARI group and from the European Society of Nephrology (represented by Trond Geir Jenssen). The guideline development group considered all the valuable comments made and, where appropriate, we incorporated the suggested changes in the final document.

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James Heaf is a nephrology consultant at Herlev Hospital, University of Copenhagen, with special responsibility for PD. He is the director of the Danish Nephrology Registry, and a member of the ERA-EDTA Registry committee. His MD thesis on the subject of aluminium nephrology was published in 1992. He has published more than 130 papers on a number of nephrological subjects including mineral bone disease, PD, epidemiology and uraemia progression. He is a reviewer for several nephrology journals.

Olof Heimbürger is consultant nephrologist and Director of PD at the Department of Renal Medicine, Karolinska University Hospital, Stockholm, Sweden and Associate Professor of Nephrology at the Karolinska Institutet. He has more than 25 years of clinical experience in renal medicine and has published about 300 scientific papers and textbook chapters, mainly about peritoneal dialysis, nutrition, metabolism, inflammation, biomarkers, cardiovascular disease and genetics in patients with CKD. Olof Heimbürger was the Secretary of the International Society of Peritoneal Dialysis 2006–2014 and is a member of the ERBP advisory board. He is a regular reviewer of scientific papers for various journals on nephrology.

Kitty Jager is an Associate Professor of Medical Informatics at the Academic Medical Centre in Amsterdam, the Netherlands. She has authored and co-authored over 210 scientific papers on the epidemiology of kidney disease, quality of care in renal replacement therapy and related research methods. She is the Director of the ERA-EDTA Registry and leads a number of other European renal registries and studies. Currently, she is a Perspectives Editor for renal epidemiology for Nephrology Dialysis Transplantation and serves as an editor for a number of other journals. In addition, she is a reviewer for various nephrology journals.
Hakan Nacak started medical school in 2008 at the Leiden University Medical Centre in the Netherlands. In 2012 he started his PhD thesis about pre-dialysis care, specifically concerning uric acid and sodium management and initiation of dialysis. In the same year, he also started his training to become an epidemiologist. In 2012, he joined the ERBP guideline working group and is investigating optimal timing of dialysis initiation in patients with diabetes with CKD.

Maria José Soler is a consultant nephrologist at the Hospital del Mar, Barcelona, Spain. She is also an Associate Professor of Nephrology at the University of Pompeu Fabra of Barcelona, Spain. Since 2000, she has been working in the hospitalization unit and outpatient consultation within the chronic and acute kidney disease management. Her research interest has focused on diabetic nephropathy from the bench to the bedside. Dr Soler completed a fellowship in research and nephrology at the Northwestern University of Chicago, USA, in 2005–2007. She completed a doctoral thesis in 2007, on ‘Angiotensin-converting enzyme 2 in diabetic kidney disease’, and received an extraordinary PhD Award in 2007. She is author or co-author of more than 200 congress communications and peer-reviewed journal articles, covering a wide variety of topics in nephrology (clinical and experimental diabetic nephropathy, HD, transplantation). Her basic research work has been consistently funded by the National Institute of Health.

Charles Tomson has been a consultant nephrologist in Bristol since 1993 and now works at Newcastle upon Tyne. He chaired the group that developed the first UK joint guidelines on CKD, published in 2005. He was Chair of the UK Renal Registry, 2006–2010, President of the Renal Association 2010–2012, and Chair of the Joint Committee on Renal Disease of the Renal Association and the Royal College of Physicians 2012–2014. He led on the chapter on CKD with diabetes mellitus in the 2012 KDIGO guideline on blood pressure in CKD. His clinical practice includes CKD, AKI, dialysis, transplantation and metabolic stone disease.

Liesbeth Van Huffel graduated from the Ghent Medical University in 2009 and started her fellowship in endocrinology in 2013 with Professor Jean-Marc Kaufman. Along with her clinical training, Dr Van Huffel has worked on several projects about the effect of exercise and diet in patients with diabetes. She joined the ERBP fellows group for this project in September 2013. She is currently finishing her fellowship endocrinology at the Ghent University.

Steven Van Laecke is a consultant nephrologist at the Ghent University Hospital in Belgium and graduated in 2000. He has published clinical research especially concerning his main topics of interest, which are transplantation and CKD. In 2012, he completed his PhD in Medical Science on the role of magnesium in transplantation. He is a regular reviewer of scientific papers in the field of transplantation and clinical nephrology.

Laurent Weekers is a Chief of Clinics in the Nephrology and Transplantation Unit at the Liege University Hospital, Belgium. He has trained both in diabetology and nephrology and has published several papers on the risk factors for diabetic nephropathy. He is one of the current Belgian representatives at Eurotransplant Kidney Transplant Advisory Committee.

Andrzej Wieçek, MD, PhD, FRCP (Edin.), FERA initially studied for his medical degree from 1974 to 1980 in Katowice, Poland. From 1985 to 1986 and in 1993 he held scientific scholarships in nephrology at the University of Heidelberg, Germany. Professor Wieçek has furthermore received a membership of the Polish Academy of Arts and Sciences (2011), Polish Academy of Science (2013). In 2011, he received a Doctor Honoris Causa from the Semmelweis University in Budapest, Hungary and is an honorary member of the Romanian Society of Nephrology (2003). Professor Wieçek is the author or co-author of more than 600 scientific papers and more than 100 book chapters, as well as co-editor of 20 books in the field of hypertension and kidney diseases.

During recent years, Professor Wieçek has served in eminent positions such as President of the Polish Society of Hypertension (2000–2002); President of the Polish Society of Nephrology (2007–2010); Council member of the Polish Society of Transplantology (2003–2005); Council member of the ERA-EDTA (1999–2002 and 2006–2009); Secretary-Treasurer of the ERA-EDTA (2011–2014); President of the ERA-EDTA (2014–2017) and member of numerous KDIGO expert groups and director boards.

ERBP methods support team

Davide Bolignano is a specialist registrar in nephrology, working as full researcher at the Institute of Clinical Physiology of the National Council of Research in Reggio Calabria, Italy. In 2011, he joined the ERBP group as a member of the methods support team. Dr Bolignano is currently pursuing a PhD in renal pathophysiology at the Erasmus University of Rotterdam. In 2012 he trained in guideline development and systematic reviews methodology at the Cochrane renal group in Sydney, Australia, and in 2014 he obtained the Global Clinical Scholars Research Training Program in Methods and Conduct of Clinical Research Certificate at the Harvard Medical School. Dr Bolignano is currently author/co-author of more than 90 articles on various topics in nephrology and a regular reviewer for several scientific journals.

Christian Drechsler is a consultant nephrologist at the University of Würzburg in Germany. She has also been trained in clinical epidemiology at the Netherlands Institute of Health Sciences in Rotterdam, and the Department of Clinical Epidemiology in Leiden, the Netherlands. She graduated with a Master of Science in 2007 and with a PhD in clinical epidemiology in 2010. At the University Hospital Würzburg, she is doing clinical practice in nephrology as well as research activities. Her research work focuses on sudden cardiac death and the clinical epidemiology of cardiac and diabetic complications in CKD. She has published a variety of scientific papers and is a regular reviewer of scientific papers in nephrology. She joined the methods support team of ERBP in 2014.

Maria Haller graduated from the Medical University Vienna in 2006 and started her renal fellowship in 2008 with Professor Rainer Oberbauer. Along with her clinical training,
Dr Haller worked on renal research projects, such as a cost effectiveness analysis of renal replacement therapy and the molecular mechanisms of sirolimus-induced phosphaturia at the University of Zurich. Additionally, Maria obtained a Master’s Degree in Health Care Management at the Vienna University of Economics and Business in 2012.

Ionut Nistor is a nephrologist at the Nephrology Department, ‘Gr. T. Popa’ University of Medicine and Pharmacy, Iasi, Romania. He started a PhD in 2011, on the evidence for treatment of patients with diabetes who developed CKD 3b/4/5. Dr Nistor joined the European Renal Best Practice (ERBP) group from August 2011 as an ERBP fellow in the methods team. His research interests also include cardiovascular complications in CKD patients, dialysis and transplant patients. Dr Nistor was trained in the skills of guideline-related literature searching and evidence grading from the Cochrane Renal Group. He worked as Honorary Research Fellow with the Cochrane Renal Group (based at the Centre for Kidney Research, The Children’s Hospital at Westmead, Sydney, Australia).

Evi Nagler is a specialist registrar in nephrology at the University of Ghent, Belgium, currently pursuing a PhD in clinical epidemiology. She was the first of four fellows to be enrolled in a fellowship programme, awarded by European Renal Best Practice, to train in guideline development methodology. As member of the methods support team she is primarily responsible for providing methodological support to the guideline development working groups. In addition, she is involved with process management and as such engaged in optimizing the tools and techniques used in the management of the guideline development process.

Sabine van der Veer worked as an IT project manager in the Academic Medical Centre (Amsterdam, the Netherlands) after obtaining her degree in medical informatics at the University of Amsterdam. In 2007, she started a PhD project under the supervision of Professor Kitty Jager, entitled ‘Systematic quality improvement in healthcare: clinical performance measurement and registry-based feedback’. Within this project she developed an instrument to measure dialysis patient experience, investigated implementation of best renal practice as a NephroQUEST research fellow at the UK Renal Registry (Bristol, UK), and conducted a cluster RCT among Dutch intensive care units to evaluate the effectiveness of clinical performance feedback. She defended her PhD thesis in June 2012.

She joined the ERBP fellow group in February 2012. Her focus is on investigating and improving the dissemination and implementation of guidance on renal best practice in Europe; this includes documents produced by the ERBP as well as by other organisations.

Wim Van Biesen is Professor of Nephrology at the Ghent University Hospital, Belgium.

He is author and co-author of more than 250 articles dealing with a wide variety of topics in nephrology (PD, HD, CKD management) and intensive care nephrology. He is the current chair of ERBP. He is also theme editor for dialysis for Nephrology Dialysis Transplantation and is a member of the editorial board of various other journals. He is a regular reviewer of scientific papers for different journals on nephrology, intensive care and epidemiology.

Guideline development group declaration of interest

DR HENK BILO

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party? No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party? No

3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party? Research grants

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4. Other potential conflicts of interest? No

5. Is there anything else that might influence your judgement, or might be perceived to do so? No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA Yes, involved in standard committees of the Dutch primary care organisation, Dutch consultant physician organisation

DR DAVIDE BOLIGNANO

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party? No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party? No

3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party? No

4. Other potential conflicts of interest? No

5. Is there anything else that might influence your judgement, or might be perceived to do so? No

By guest on August 26, 2015 http://ndt.oxfordjournals.org/ Downloaded from
6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
Yes. ERA-EDTA Young Nephrologists Platform Board member

DR LUIS COENTRAO
1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?
No
2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?
No
3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?
No
4. Other potential conflicts of interest?
No
5. Is there anything else that might influence your judgement, or might be perceived to do so?
No
6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
No

DR CECILE COUCHOUD
1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?
No
2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?
No
3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?
No
4. Other potential conflicts of interest?
No
5. Is there anything else that might influence your judgement, or might be perceived to do so?
No
6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
Yes. KDIGO, French Society of Nephrology

PROF. ADRIAN COVIC
1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?
No
2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?
No
3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?
No
4. Other potential conflicts of interest?
No
5. Is there anything else that might influence your judgement, or might be perceived to do so?
No
6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
No

DR CHRISTIANE DRECHSLER
1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?
No
2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?
No
3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?
No
4. Other potential conflicts of interest?
No
5. Is there anything else that might influence your judgement, or might be perceived to do so?
No
6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
Yes. ASN, German Society of Nephrology

PROF. LUIGI GNUDI
1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?
No
2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?
No
3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?
No
4. Other potential conflicts of interest?
No
5. Is there anything else that might influence your judgement, or might be perceived to do so?
No
6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
Yes. KDIGO, French Society of Nephrology

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Lecturing, chairing lectures or participation in symposia/panel discussions

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3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?

Principal investigator

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Research grant

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Other type of grant

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4. Other potential conflicts of interest?

No

5. Is there anything else that might influence your judgement, or might be perceived to do so?

No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA?

No

PROF. DAVID GOLDSMITH

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?

Consultant for company

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2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?

Giving expert/scientific advice
### Lecturing, chairing lectures or participation in symposia/panel discussions

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### Conference/meeting registration fees paid or reimbursed

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### 3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party? Other position in clinical trial

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### 4. Other potential conflicts of interest?

No

5. Is there anything else that might influence your judgement, or might be perceived to do so?

No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA

Yes. ISPD, ASN

**PROF. OLOF HEIMBURGER**

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party? Consultant for company

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### 2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?

Lecturing, chairing lectures or participation in symposia/panel discussions

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3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?

Principal investigator

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4. Other potential conflicts of interest?

Related to, or have close relationship with, someone in company or interest group

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<tbody>
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<td>Nature of interest</td>
<td>My brother is employed by Abbvie</td>
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</table>

5. Is there anything else that might influence your judgement, or might be perceived to do so?

No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA

Yes. Representative for Sweden in the UEMS Renal Section

PROF. KITTY J JAGER

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?

No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?

No

3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?

No

4. Other potential conflicts of interest?

No

5. Is there anything else that might influence your judgement, or might be perceived to do so?

No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA

No

DR EVI NAGLER

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?

No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?

No

3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?

Academic position funded by company or interested party

4. Other potential conflicts of interest?

No

5. Is there anything else that might influence your judgement, or might be perceived to do so?

No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA

No

DR IONUT NISTOR

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?

No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?

No

3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?

No

4. Other potential conflicts of interest?

No

5. Is there anything else that might influence your judgement, or might be perceived to do so?

No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA

No

DR HAKAN NACAK

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?

No
3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?
   No

4. Other potential conflicts of interest?
   No

5. Is there anything else that might influence your judgement, or might be perceived to do so?
   No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
   No

DR MARIA JOSE SOLER ROMEO
1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?
   No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?
   Other type of involvement

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3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?
   Research grant

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4. Other potential conflicts of interest?
   No

5. Is there anything else that might influence your judgement, or might be perceived to do so?
   No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
   No

DR CHARLES R.V. TOMSON
1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?
   No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?
   Yes

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Lecturing, chairing lectures or participation in symposia/panel discussions

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3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?
   No

4. Other potential conflicts of interest?
   No

5. Is there anything else that might influence your judgement, or might be perceived to do so?
   No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
   No

DR LIESBETH VAN Huffel
1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?
   No
2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?
   Lecturing, chairing lectures or participation in symposia/panel discussions

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3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?

No

4. Other potential conflicts of interest?

No

5. Is there anything else that might influence your judgement, or might be perceived to do so?

No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA

No

DR STEVEN VAN LAECKE

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?

No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?

No

3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?

No

4. Other potential conflicts of interest?

No

5. Is there anything else that might influence your judgement, or might be perceived to do so?

No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA

No

PROF. ANDRZEJ JAN WIECEK

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?

No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?

Giving expert/scientific advice

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3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?

No

4. Other potential conflicts of interest?

No

5. Is there anything else that might influence your judgement, or might be perceived to do so?

No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA

No

DR LAURENT WEEKERS

1. Do you have, or have you had during the past 2 years, any formal association with a company or other interested party?

No

2. Do you have, or have you had during the past 2 years, any of the following types of association with a company or other interested party?

Giving expert/scientific advice

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Lecturing, chairing lectures or participation in symposia/panel discussions

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Date 2013–2014

| Company or interest group | Roche Diagnostics Belgium |
| Value      | Less than EUR 1000 |
| Payment made to  | Personal account |
Conference/meeting registration fees paid or reimbursed

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Travel or accommodation provided or reimbursed

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3. Do you have, or have you had during the past 2 years, any job, position, research grant, or other grant that involved a company or other interested party?

Research grant

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<td>Research grant</td>
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<td>Nature of restriction</td>
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</table>

4. Other potential conflicts of interest?
No

5. Is there anything else that might influence your judgement, or might be perceived to do so?
No

6. Member (current) of any kind of committee, board, WG, etc. of another scientific association with similar aims as ERA-EDTA
No

APPENDIX 2.
REVIEW QUESTIONS: PICOM FORMAT

Chapter 1.1. Should patients with diabetes and CKD stage 5 start with PD or HD as a first modality?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus (comorbidity or diabetic nephropathy) and chronic kidney disease CKD stage 5 Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>PD of any kind as first modality (1) Continuous ambulatory PD: CAPD (2) Automated PD: APD</td>
</tr>
<tr>
<td>Comparator</td>
<td>HD of any kind as first modality (on Day 90) (1) Conventional HD (2) Haemofiltration (3) Haemodiafiltration (4) Daily HD</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Critical outcomes</td>
</tr>
</tbody>
</table>

Methodology
Systematic reviews RCTs Cohort studies Registry studies

Chapter 1.2. Should patients with diabetes and CKD stage 5 start dialysis earlier, i.e. before becoming symptomatic, than patients without diabetes?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus (comorbidity or diabetic nephropathy) and chronic kidney disease CKD stage 5 Adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Start dialysis without clinical symptoms or biochemical alterations at a predefined fixed point of clearance</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Question-specific outcome measures (1) Need for temporary HD catheter: important</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic reviews RCTs Cohort studies Registry studies</td>
</tr>
</tbody>
</table>
Chapter 1.3. In patients with diabetes and CKD stage 5, should a native fistula, a graft or a tunnelled catheter be preferred as initial access?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus (comorbidity or diabetic nephropathy) and chronic kidney disease CKD stage 5 Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Tunnelled catheter any position (1) Jugular vein (2) Femoral vein (3) Subclavian vein Graft any position (1) Radial artery (2) Cubital artery (3) Humeral artery</td>
</tr>
<tr>
<td>Comparator</td>
<td>Native fistula any position (1) Radial artery (2) Cubital artery (3) Humeral artery</td>
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</table>

Chapter 1.4. What is the benefit of renal transplantation for dialysis patients with diabetes and CKD stage 5? A. Is there evidence for a selection bias in observational studies?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus (comorbidity or diabetic nephropathy) and renal failure on dialysis Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Percentage of dialysis patients with diabetes mellitus registered on waiting list</td>
</tr>
<tr>
<td>Comparator</td>
<td>Percentage of other patients registered on the waiting list</td>
</tr>
<tr>
<td>Outcome</td>
<td>Not applicable</td>
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<tr>
<td>Methodology</td>
<td>Registry data Cross-sectional studies</td>
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Chapter 1.4. A. Is there a benefit of renal transplantation for dialysis patients with diabetes and CKD stage 5?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus (comorbidity or diabetic nephropathy) and renal failure on dialysis Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Kidney transplantation (1) Cadaveric kidney transplantation alone (2) Living-donor kidney transplantation alone (3) Simultaneous cadaveric kidney-pancreas transplantation</td>
</tr>
<tr>
<td>Comparator</td>
<td>Dialysis of any kind in patients on the waiting list (1) Continuous ambulatory PD – CAPD</td>
</tr>
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</table>

Chapter 2.1. A. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we aim to lower HbA1C by tighter glycaemic control?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus (comorbidity or diabetic nephropathy) and CKD stage 3b or higher (eGFR &lt;45 mL/min/1.73 m²) Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Intensive glycaemic control: as measured by HbA1C</td>
</tr>
<tr>
<td>Comparator</td>
<td>Conventional glycaemic control: as measured by HbA1C</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Critical outcomes (1) Survival/mortality (2) Progression to end-stage kidney disease (3) Quality of life (4) Major morbidity events (a) Myocardial infarction (b) Stroke (c) Amputation (d) Loss of vision</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic reviews RCTs Cohort studies Registry studies</td>
</tr>
</tbody>
</table>

Highly important outcomes (1) Hospital admissions (2) Deterioration of residual renal function when already on dialysis (3) Patient satisfaction (4) Minor morbidity events (a) Hypoglycaemia (b) Delayed wound healing (c) Infection (d) Visual disturbances (e) Pain (f) Functional status Moderately important outcomes (1) Hyperglycaemia (2) Glycaemic control (a) Glycaemic control (b) Self-measurement Question-specific outcome measures (1) Keto-acidosis: critically important |

Methodology | Systematic reviews RCTs Cohort studies Registry studies |
**Chapter 2.1. B.** Is an aggressive treatment strategy (in number of injections and controls and follow-up) superior to a more relaxed treatment strategy in patients with diabetes and CKD stage 3b or higher (eGFR < 45 mL/min/1.73 m²) and using insulin?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus (comorbidity or diabetic nephropathy) and chronic kidney disease CKD stage 5 Adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Aggressive regimen either defined as more frequent injections, more frequent monitoring or adapted insulin</td>
</tr>
<tr>
<td>Comparator</td>
<td>Relaxed regimen with limited controls and insulin in one or maximum two injections</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic reviews RCTs Cohort studies Registry studies</td>
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</tbody>
</table>

**Chapter 2.2. In patients with diabetes and CKD stage 3b or higher (eGFR < 45 mL/min/1.73 m²) or on dialysis, are there better alternatives than HbA1c to estimate glycaemic control?**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus (comorbidity or diabetic nephropathy) and CKD stage 3b or higher (eGFR &lt; 45 mL/min/1.73 m²) Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
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<tbody>
<tr>
<td>Intervention</td>
<td>Glycaemic control evaluated with: (1) Glycated albumin (2) Self-measurement point of care (3) Continuous registration (4) Others methods</td>
</tr>
<tr>
<td>Comparator</td>
<td>Glycaemic control evaluated with HbA1c as reference standard</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic reviews RCTs Cohort studies Registry studies</td>
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</tbody>
</table>

**Chapter 2.3. A.** Is any oral drug superior to another in terms of mortality/complications/glycaemic control in diabetic patients with CKD stage 3b or higher (eGFR < 45 mL/min/1.73 m²)?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus and CKD stage 3b or higher (eGFR &lt; 45 mL/min/1.73 m²) Children, adults, aged adults Diabetes mellitus type 1 or type 2 Metformin Sulfonylurea Glitipins DDP4 inhibitor Glitazones Acarbose Any other oral drug for reducing hyperglycaemia</th>
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<tbody>
<tr>
<td>Intervention</td>
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</tr>
<tr>
<td>Comparator</td>
<td>Any oral hypoglycaemic drug</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Question-specific outcome measures (1) Weight gain: moderately important</td>
</tr>
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<td>Methodology</td>
<td>Systematic review RCTs Cohort studies Registry studies</td>
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</table>

**Chapter 2.3. B.** In patients with diabetes and CKD stage 3b or higher (eGFR < 45 mL/min/1.73 m²), is maximal oral therapy better than starting/adding insulin in an earlier stage?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus (comorbidity or diabetic nephropathy) and CKD stage 3b or higher (eGFR &lt; 45 mL/min/1.73 m²) Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Start insulin as first line or as step up to maximum dose of one oral agent</td>
</tr>
<tr>
<td>Comparator</td>
<td>Maximal oral therapy (all oral options in all combinations at maximum allowed dosage)</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Question-specific outcome measures (1) Weight gain: moderately important</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic reviews RCTs Cohort studies Registry studies</td>
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</tbody>
</table>

**Chapter 3.1. In patients with diabetes and CKD stage 3b or higher (eGFR < 45 mL/min/1.73 m²) and CAD, is PCI or CABG or conservative treatment to be preferred?**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus and CKD stage 3b or higher (eGFR &lt; 45 mL/min/1.73 m² or on dialysis) with established cardiac ischaemia/CAD Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
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<tbody>
<tr>
<td>Intervention</td>
<td>Coronary artery bypass grafting (CABG) PCI</td>
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<tr>
<td>Comparator</td>
<td>Medical treatment/management</td>
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<tr>
<td>Outcome</td>
<td>Core outcome measures Question-specific outcome measures (1) Symptom control: dyspnoea, chest pain: highly important</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic review RCTs Cohort studies Registry studies</td>
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</table>

**Chapter 3.2. In patients with diabetes and CKD stage 3b or higher (eGFR < 45 mL/min/1.73 m²) and with a cardiac indication (heart failure, ischaemic heart disease, hypertension), should we prescribe inhibitors of the RAAS system or aldosterone-antagonists as cardiovascular prevention?**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus and CKD stage 3b or higher (eGFR &lt; 45 mL/min/1.73 m² or on dialysis) with a cardiac indication (heart failure, ischaemic heart disease, hypertension) for RAAS or aldosterone treatment Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
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</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Inhibitor of the RAAS system Aldosterone antagonist Any combination</td>
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<tr>
<td>Comparator</td>
<td>Placebo or no treatment</td>
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<tr>
<td>Outcome</td>
<td>Core outcome measures Question-specific outcome measures (1) Sudden death: critically important</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic review RCTs Cohort studies Registry studies</td>
</tr>
</tbody>
</table>
Chapter 3.3. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we prescribe beta blockers to prevent sudden cardiac death?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus and CKD stage 3b or higher (eGFR &lt;45 mL/min/1.73 m² or on dialysis) Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Beta blocker (any type)</td>
</tr>
<tr>
<td>Comparator</td>
<td>Placebo or no treatment</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Question-specific outcome measures (1) Sudden death: critically important</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic review RCTs Cohort studies Registry studies</td>
</tr>
</tbody>
</table>

Chapter 3.4. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we aim at lower blood pressure targets than in the general population?

A Cochrane review of sufficient quality was used to answer this question.

Chapter 3.5. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we prescribe lipid-lowering therapy in primary prevention?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus and CKD stage 3b or higher (eGFR &lt;45 mL/min/1.73 m² or on dialysis) Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Lipid-lowering therapy (a) Statin (all compounds) (b) Fibrate (all compounds) (c) Any other class of agents</td>
</tr>
<tr>
<td>Comparator</td>
<td>Placebo or no treatment Any other class of agents Other strategies</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Question-specific outcome measures (1) Cancer: critically important (2) Rhabdomyolysis: highly important</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic review RCTs Cohort studies Registry studies</td>
</tr>
</tbody>
</table>

Chapter 3.6. A. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we recommend interventions aimed at increasing energy expenditure and physical activity?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus and CKD stage 3b or higher (eGFR &lt;45 mL/min/1.73 m² or on dialysis) Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Structured education/intervention aimed at increasing energy expenditure and/or physical activity (1) Advise to exercise (2) Structured education programmes including advice on exercise (3) Provision of a supervised exercise programme (4) Provision of exercise bikes (for instance during HD)</td>
</tr>
<tr>
<td>Comparator</td>
<td>Standard care</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Question-specific outcome measures (1) Depression symptoms: critically important (2) Exercise capacity: highly important (3) Weight loss: moderately important (4) Insulin sensitivity: moderately important (5) Improved efficiency of HD (6) Adherence to treatment strategy</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic review RCTs Cohort studies Registry studies</td>
</tr>
</tbody>
</table>

Chapter 3.6. B. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we recommend interventions aimed at reducing energy intake?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus and CKD stage 3b or higher (eGFR &lt;45 mL/min/1.73 m² or on dialysis) Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Structured education/intervention aimed at decreasing energy intake (1) Dietary advice (2) Structured dietary plans supervised by a dietician</td>
</tr>
<tr>
<td>Comparator</td>
<td>Standard care</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Question specific outcome measures (1) Weight loss: moderately important (2) Insulin sensitivity: moderately important (3) Blood pressure: moderately important - surrogate outcome (4) Proteinuria: moderately important - surrogate outcome (5) Adherence to treatment strategy</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic review RCTs Cohort studies Registry studies</td>
</tr>
</tbody>
</table>

Chapter 3.7. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should antiplatelet therapy be recommended, regardless of its cardiovascular risk?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Patients with diabetes mellitus and CKD stage 3b or higher (eGFR &lt;45 mL/min/1.73 m² or on dialysis) Children, adults, aged adults Diabetes mellitus type 1 or type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Platelet aggregation inhibitors Aspirin Dipyridamole Glycoprotein IIb/IIIa inhibitors</td>
</tr>
<tr>
<td>Comparator</td>
<td>Placebo</td>
</tr>
<tr>
<td>Outcome</td>
<td>Core outcome measures Question specific outcome measures (1) Need for blood transfusion (2) Bleeding (3) Adherence to treatment strategy</td>
</tr>
<tr>
<td>Methodology</td>
<td>Systematic review RCTs Cohort studies Registry studies</td>
</tr>
</tbody>
</table>
APPENDIX 3. SEARCH STRATEGIES

Chapter 1.1. Should patients with diabetes and CKD stage 5 start with PD or HD as a first modality?

MEDLINE
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (haemodiafiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. or/1-14
16. exp diabetes mellitus/
17. exp Diabetes Mellitus, Type 1/
18. exp Diabetes Mellitus, Type 2/
19. Diabetic Nephropathies/
20. diabet$.tw.
21. (niddm or iddm).tw.
22. or/16-21
23. ((first or dialysis or choice or best) adj3 modality).tw.
24. ((first or dialysis or modality or starting or best) adj3 choice).tw.
25. ((dialysis or modality or best) adj3 start).tw.
26. ((begin or first or initiat$) adj3 dialysis).tw.
27. or/23-26
28. 15 and 22 and 27

COCHRANE CENTRAL
#1 dialysis,ti,ab,kw
#2 h*emofiltration:ti,ab,kw
#3 h*emodiafiltration:ti,ab,kw
#4 (end-stage renal or end-stage kidney or endstage renal or endstage kidney):ti,ab,kw
#5 (ESRF or ESKF or ESRD or ESKD):ti,ab,kw
#6 (chronic kidney or chronic renal):ti,ab,kw
#7 (CKF or CKD or CRF or CRD):ti,ab,kw
#8 (CAPD or CCPD or APD):ti,ab,kw
#9 (predialysis or pre-dialysis):ti,ab,kw
#10 MeSH descriptor Kidney Failure, Chronic, this term only
#11 MeSH descriptor Renal Replacement Therapy explode all trees
#12 MeSH descriptor Renal Insufficiency, Chronic explode all trees
#13 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12)
#14 MeSH descriptor Diabetes Mellitus, this term only
#15 MeSH descriptor Diabetes Mellitus, Type 1 explode all trees
#16 MeSH descriptor Diabetes Mellitus, Type 2 explode all trees
#17 MeSH descriptor Diabetic Nephropathies explode all trees
#18 diabet*:ti,ab,kw
#19 (niddm or iddm):ab,ti,kw
#20 (#14 OR #15 OR #16 OR #17 OR #18 OR #19)
#21 (#13 AND #20)
#22 first modality:ti,ab,kw
#23 dialysis modality:ti,ab,kw
#24 choice modality:ti,ab,kw
#25 best modality:ti,ab,kw
#26 first choice:ti,ab,kw
#27 dialysis choice:ti,ab,kw
#28 modality choice:ti,ab,kw
#29 starting choice:ti,ab,kw
#30 best choice:ti,ab,kw
#31 dialysis begin:ti,ab,kw
#32 first dialysis:ti,ab,kw
#33 initiat*: dialysis:ti,ab,kw
#34 (#22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32)
#35 (#21 AND #34)

Chapter 1.2. Should patients with diabetes and CKD stage 5 start dialysis earlier, i.e. before becoming symptomatic, than patients without diabetes?

MEDLINE
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (haemodiafiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. or/1-14
16. exp diabetes mellitus/
17. exp Diabetes Mellitus, Type 1/
18. exp Diabetes Mellitus, Type 2/
19. Diabetic Nephropathies/
20. diabet$.tw.
21. (niddm or iddm).tw.
22. or/16-21
23. ((ideal or preemptive or pre-emptive or early) adj11 start).tw.
24. ((ideal or preemptive or pre-emptive or early) adj11 initiation).tw.
25. ((ideal or preemptive or pre-emptive or early) adj11 timing).tw.
26. ((begin or first or initiat$ or start$) adj11 dialysis).tw.
27. (early-start or late-start),tw
28. ((ideal or preemptive or pre-emptive or early) adj11 dialysis),tw
29. or/23-27
30. 15 and 22 and 28
31. limit 30 to human
32. (comment or editorial or historical-article).pt.
33. 31 not 32

**MEDLINE**
1. randomized controlled trial.pt.
2. controlled clinical trial.pt.
3. randomi?ed.ab,ti.
4. placebo$.ab,ti.
5. drug therapy.fs.
6. randomly,ab,ti.
7. trial$.ab,ti.
8. group$.ab,ti.
9. or/1-8
11. exp Technology Assessment, Biomedical/

**COCHRANE CENTRAL**
#1 fistula*:ti,ab,kw
#2 (shunt or shunts):ti,ab,kw
#3 (graft or grafts):ti,ab,kw
#4 (end-stage renal or end-stage kidney or endstage renal or endstage kidney):ti,ab,kw
#5 (ESRF or ESKF or ESRD or ESKD):ti,ab,kw
#6 (chronic kidney or chronic renal):ti,ab,kw
#7 (CKF or CKD or CRF or CRD):ti,ab,kw
#8 (CAPD or CCPD or APD):ti,ab,kw
#9 (predialysis or pre-dialysis):ti,ab,kw
#10 MeSH descriptor Kidney Failure, Chronic, this term only
#11 MeSH descriptor Renal Replacement Therapy explode all trees
#12 MeSH descriptor Renal Insufficiency, Chronic explode all trees
#13 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12)
#14 MeSH descriptor Diabetes Mellitus, this term only
#15 MeSH descriptor Diabetes Mellitus, Type 1 explode all trees
#16 MeSH descriptor Diabetes Mellitus, Type 2 explode all trees
#17 MeSH descriptor Diabetic Nephropathies explode all trees
#18 diabet*:ti,ab,kw
#19 (niddm or iddm):ab,ti,kw
#20 (#14 OR #15 OR #16 OR #17 OR #18 OR #19)
#21 (#13 AND #20)
#22 (preemptive or preemptive or first or start* or initiat* or begin):ti,ab,kw
#23 (#22 AND #1)
#24 (#21 AND #23)

**Chapter 1.3. In patients with diabetes and CKD stage 5, should a native fistula, a graft or a tunnelled catheter be preferred as initial access?**

**MEDLINE**
1. randomized controlled trial.pt.
2. controlled clinical trial.pt.
3. randomi?ed.ab,ti.
4. placebo$.ab,ti.
5. drug therapy.fs.
6. randomly,ab,ti.
7. trial$.ab,ti.
8. group$.ab,ti.
9. or/1-8
11. exp Technology Assessment, Biomedical/
12. exp Meta-analysis/
13. exp Meta-analysis as topic/
15. hta.tw,ot.
16. (meta analy$ or metaanaly$ or meta?analy$).tw,ot.
17. exp Cohort studies/
18. Incidence.tw.
19. exp mortality/
20. exp follow-up studies/
21. mo.fs.
22. prognos$.tw.
23. predict$.tw.
24. course.tw.
25. exp survival analysis/
26. or/10-25
27. (comment or editorial or historical-article).pt.
28. 26 not 27
29. 9 or 28
30. Arteriovenous Fistula/
31. Arteriovenous Shunt, Surgical/
32. Blood Vessel Prosthesis/
33. Blood Vessel Prosthesis Implantation/
34. (vascular access or venous access).tw.
35. (dialysis access or haemodialysis access or haemodialysis access).tw.
36. Catheterization, Central Venous/
37. fistula$.tw.
38. (graft or grafts).tw.
39. (shunt or shunts).tw.
40. prosthesis.tw.
41. tunne$.tw.
42. catheter$.tw.
43. central line$.tw.
44. (AVF or AVG or CVC).tw.
45. or/30-44
46. Kidney Failure/
47. exp Renal Insufficiency, Chronic/
48. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
49. (ESRF or ESKF or ESRD or ESKD).tw.
50. (chronic kidney or chronic renal).tw.
51. (CKF or CKD or CRF or CRD).tw.
52. predialysis.tw.
53. *Kidney Transplantation/ or exp *Peritoneal Dialysis/
54. exp diabetes mellitus/
55. exp Diabetes Mellitus, Type 1/
56. exp Diabetes Mellitus, Type 2/
57. Diabetic Nephropathies/
58. diabet$.tw.
59. (niddm or iddm).tw.
60. or/54-59
61. or/46-52
62. 61 not 53
63. 45 and 60 and 62

**COCHRANE CENTRAL**
#1 fistula*:ti,ab,kw
#2. (shunt or shunts):ti,ab,kw
#3. (graft or grafts*):ti,ab,kw
Chapter 1.4. What is the benefit of renal transplantation for dialysis patients with diabetes and CKD stage 5?

A. Is there evidence for a selection bias in observational studies?

MEDLINE

1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (haemodiafiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. (haemodiafiltration or haemodiafiltration).tw.
16. exp diabetes mellitus/
17. exp Diabetes Mellitus, Type 1/
18. exp Diabetes Mellitus, Type 2/
19. diabet$.tw.
20. (niddm or iddm).tw.
21. or/1-20
22. (haemodiafiltration or haemodiafiltration).tw.
23. diabet* nephropath*.tw.
24. (diabet* adj5 (kidney or renal)).tw.
25. random controlled trial.pt.
26. randomized.ab.
27. placebo.ab.
28. clinical trials as topic.sh.
29. randomly.ab.
30. trial.ti.
31. or/30-34
32. 33 not 34
33. limit 32 to human
34. (comment or editorial or historical-article).pt.
35. 33 not 34
36. randomized controlled trial.pt.
37. controlled clinical trial.pt.
38. randomized.ab.
39. placebo.ab.
40. clinical trials as topic.sh.
41. randomly.ab.
42. trial.ti.
43. or/30-34
44. exp animals/ not humans.sh.
45. 43 not 44
46. 35 and 45

COCHRANE CENTRAL
#1 dialysis,ti,ab,kw
#2 h*emo*filtration,ti,ab,kw
#3 h*emodiafiltration,ti,ab,kw
#4 (end-stage renal or end-stage kidney or endstage renal or endstage kidney),ti,ab,kw

Chapter 1.4. What is the benefit of renal transplantation for dialysis patients with diabetes and CKD stage 5?

B. What is the benefit of renal transplantation for dialysis patients with diabetes and CKD stage 5?

MEDLINE

1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (haemodiafiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. or/1-14
16. exp diabetes mellitus/
17. exp Diabetes Mellitus, Type 1/
18. exp Diabetes Mellitus, Type 2/
19. diabet$.tw.
20. (niddm or iddm).tw.
21. or/16-20
22. 15 and 21
23. Diabetic Nephropathies/
24. diabet* nephropath*.tw.
25. (diabet* adj5 (kidney or renal)).tw.
26. or/23-25
27. 22 or 26
28. kidney transplantation/
29. kidney transplant$.tw.
30. renal transplant$.tw.
31. or/28-30
32. 27 and 31
33. limit 32 to human
34. (comment or editorial or historical-article).pt.
35. 33 not 34
36. randomized controlled trial.pt.
37. controlled clinical trial.pt.
38. randomized.ab.
39. placebo.ab.
40. clinical trials as topic.sh.
41. randomly.ab.
42. trial.ti.
43. or/30-34
44. exp animals/ not humans.sh.
45. 43 not 44
46. 35 and 45

COCHRANE CENTRAL
#1 dialysis,ti,ab,kw
#2 h*emo*filtration,ti,ab,kw
#3 h*emodiafiltration,ti,ab,kw
#4 (end-stage renal or end-stage kidney or endstage renal or endstage kidney),ti,ab,kw
Chapter 2.1

C. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m^2), should we aim to lower HbA1C by more tight glycaemic control?

MEDLINE search strategy
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (haemofiltration or haemofiltration).tw.
8. (haemodiafiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD):ti,ab,kw
11. (chronic kidney or chronic renal):ti,ab,kw
12. (CKF or CKD or CRF or CRD):ti,ab,kw
13. (CAPD or CCPD or APD):ti,ab,kw
14. (predialysis or pre-dialysis):ti,ab,kw
15. MeSH descriptor Kidney Failure, Chronic, this term only
16. MeSH descriptor Renal Replacement Therapy explode all trees
17. MeSH descriptor Renal Insufficiency, Chronic explode all trees
18. (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12)
19. MeSH descriptor Diabetes Mellitus, this term only
20. MeSH descriptor Renal Insufficiency, Chronic explode all trees
21. MeSH descriptor Diabetes Mellitus, Type 1 explode all trees
22. MeSH descriptor Diabetes Mellitus, Type 2 explode all trees
23. MeSH descriptor Diabetes Mellitus, Type 2 explode all trees
24. MeSH descriptor Diabetic Nephropathies explode all trees
25. diabet*:ti,ab,kw
26. (niddm or iddm):ab,ti,kw
27. (#14 OR #15 OR #16 OR #17 OR #18 OR #19)
28. kidney transplantation/
29. kidney transplant*.tw.
30. renal transplant*.tw.
31. (#21 OR #22 OR #23)
32. (#13 AND #20 AND #24)

COCHRANE CENTRAL search strategy
#1 MeSH descriptor Blood Glucose, this term only
#2 MeSH descriptor Hyperglycemia explode all trees
#3 MeSH descriptor Hemoglobin A, Glycosylated, this term only
#4 (blood glucos*):ti,ab,kw or (hyperglyc?emi*):ti,ab,kw or (h?emoglobin$ A):ti,ab,kw
#5 (HbA1C or Hb A or HbA 1c or HbA or A1Cs):ti,ab,ot.
#6 (glycosylated near/6 h?emoglobin$):ti,ab,kw
#7 (glucos$ near/3 management$):ti,ab,kw
#8 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7)
#9 MeSH descriptor Diabetes Mellitus explode all trees
#10 MeSH descriptor Diabetes Complications explode all trees
#11 (MODY):ti,ab,kw or (NIDDM ):ti,ab,kw or (T2DM):ti,ab,kw
#12 (non insulin* depend*):ti,ab,kw or (noninsulin* depend*):ti,ab,kw or (noninsulin?depend*):ti,ab,kw or (non insulin?depend):ti,ab,kw
Chapter 2.1. D. Is an aggressive treatment strategy (in number of injections and controls and follow-up) superior to a more relaxed treatment strategy in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) and using insulin?

MEDLINE search strategy
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (haemodiafiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. or/1-14
16. exp diabetes mellitus/
COCHRANE CENTRAL search strategy
#1 dialysis:ti,ab,kw
#2 h*emofiltration:ti,ab,kw
#3 h*emodiafiltration:ti,ab,kw
#4 (end-stage renal or end-stage kidney or endstage renal or endstage kidney):ti,ab,kw
#5 (ESRF or ESKF or ESRD or ESKD):ti,ab,kw
#6 (chronic kidney or chronic renal):ti,ab,kw
#7 (CKF or CKD or CRF or CRD):ti,ab,kw
#8 (CAPD or CCPD or APD):ti,ab,kw
#9 (predialysis or pre-dialysis):ti,ab,kw
#10 MeSH descriptor: [Kidney Failure, Chronic] this term only
#11 MeSH descriptor: [Renal Replacement Therapy] explode all trees
#12 MeSH descriptor: [Renal Insufficiency, Chronic] explode all trees
#13 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12
#14 MeSH descriptor: [Diabetes Mellitus] this term only
#15 MeSH descriptor: [Diabetes Mellitus, Type 1] explode all trees
#16 MeSH descriptor: [Diabetes Mellitus, Type 2] explode all trees
#17 MeSH descriptor: [Diabetic Nephropathies] explode all trees
#18 diabet*:ti,ab,kw
#19 (niddm or iddm):ab,ti,kw
#20 (#14 or #15 or #16 or #17 or #18 or #19)
#21 #13 and #20
#22 (standard or frequent* or aggresive or relaxed*) near/3 glucos* near/3 (control* or therap* or treatment or intervention* or management*):ab,ti,kw
#23 (intensi* or conventional* or regular or tight or usual or routin* or standard or frequent* or aggresive or relaxed*) near/3 glucos* near/3 (control* or therap* or treatment or intervention* or management*):ab,ti,kw
#24 (intensi* or conventional* or regular or tight or usual or routin* or standard or frequent* or aggresive or relaxed*) near/3 glucos* near/3 (control* or therap* or treatment or intervention* or management*):ab,ti,kw
#25 (intensi* or conventional* or regular or tight or usual or routin* or standard or frequent* or aggresive or relaxed*) near/3 glycaemic* near/3 (control* or therap* or treatment or intervention* or management*):ab,ti,kw
#26 (intensi* or conventional* or regular or tight or usual or routin* or standard or frequent* or aggresive or relaxed*) near/3 glycaemic* near/3 (control* or therap* or treatment or intervention* or management*):ab,ti,kw
#27 (glucos* near/3 control*):ab,ti
#28 (glucos* near/3 management*):ti,ab
#29 #22 or #23 or #24 or #25 or #26 or #27 or #28
#30 and #29

Chapter 2.2. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), are there better alternatives than HbA1c to estimate glycaemic control?

MEDLINE search strategy
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
Chapter 2.3. A. Is any oral drug superior to another in terms of mortality/complications/glycaemic control in diabetic patients with CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²)?

MEDLINE search strategy
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
9. (ESRF or ESKF or ESRD or ESKD).tw.
10. (chronic kidney or chronic renal).tw.
11. (CKF or CKD or CRF or CRD).tw.
12. (CAPD or CCPD or APD).tw.
13. (predialysis or pre-dialysis).tw.
14. or/1-14
15. exp diabetes mellitus/
16. exp Diabetes Mellitus, Type 1/
17. exp Diabetes Mellitus, Type 2/
18. MeSH descriptor Diabetes Mellitus, this term only
19. MeSH descriptor Diabetic Nephropathies explode all trees
20. diabet*:ti,ab,kw
21. (niddm or iddm):ab,ti,kw
22. (#14 OR #15 OR #16 OR #17 OR #18 OR #19)
23. (h*emoglobin NEAR A1c):ti,ab,kw
24. (glycated NEAR h*emoglobin):ti,ab,kw
25. (glycosylated NEAR h*emoglobin):ti,ab,kw
26. (glycated NEAR albumin):ti,ab,kw
27. (glycosylated NEAR albumin):ti,ab,kw
28. MeSH descriptor Hexosamines explode all trees
29. fructosamine:ti,ab,kw
30. MeSH descriptor Blood Glucose Self-Monitoring explode all trees
31. (self monitor*):ti,ab,kw
32. (self monitor'):ti,ab,kw
33. MeSH descriptor Hyperglycemia, this term only
34. MeSH descriptor Blood Glucose explode all trees
35. (#22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34)
36. (#21 AND #35)
19. Diabetic Nephropathies/
20. diabet$.tw.
21. (niddm or iddm).tw.
22. or/16-21
23. exp Hypoglycemic Agents/
24. (glucose lowering and (therap$ or agent$ or drug$)).tw.
25. (hypoglycemic and (agent$ or drug$ or therap$)).tw.
26. (antidiabet$ and (agent$ or drug$ or therap$)).tw.
27. metformin.tw.
28. Thiazolidinediones/
29. Rosiglitazone.tw.
30. Rivoglitazone.tw.
31. Pioglitazone.tw.
32. Troglitazone.tw.
33. glitazone$.tw.
34. exp Sulfonylurea Compounds/
35. (acarbose or miglitol or voglibose).tw.
36. Alogliptin.tw.
37. Linagliptin.tw.
38. (repaglinide or nateglinide or exenatide or pramlintide or benfluorex or lira-glutide or mitiglinide).tw.
39. (sitagliptin or vildagliptin or saxagliptin).tw.
40. Dipeptidyl-Peptidase IV Inhibitors/
41. Glucagon-Like Peptide 1/
42. glucagon-like peptide-1.tw.
43. Incretin mimetic$.tw.
44. alpha-Glucosidases/
45. alpha-glucosidase inhibitor$.tw.
46. Sodium-Glucose Transporter 2/
47. Sodium glucose co-transporter 2 inhibitor$.tw.
48. ddp iv inhibitor$.tw.
49. exenatide.tw.
50. or/23-49
51. randomized controlled trial.pt.
52. controlled clinical trial.pt.
53. randomi$ed.ab,ti.
54. placebo$.ab,ti.
55. drug therapy.fs.
56. randomly.ab,ti.
57. trial$.ab,ti.
58. group$.ab,ti.
59. or/51-58
60. Meta-analysis.pt.
61. exp Technology Assessment, Biomedical/
62. exp Meta-analysis/
63. exp Meta-analysis as topic/
64. (health technology adj6 assessment$).tw,ot.
65. hta.tw,ot.
66. (meta analy$ or metaanaly$ or meta$analy$).tw,ot.
67. exp Cohort studies/
68. Incidence.tw.
69. exp mortality/
70. exp follow-up studies/
71. mo.fs.
72. prognosis$.tw.
73. predict$.tw.
74. course.tw.
75. exp survival analysis/
76. or/60-75
77. (comment or editorial or historical-article).pt.
78. 76 not 77
79. 59 or 78
80. 15 and 22 and 50 and 79
81. animals/ not (humans/ and animals/)
82. 80 not 81

COCHRANE CENTRAL search strategy
#1 dialysis:ti,ab,kw
#2 h*emo$filtration:ti,ab,kw
#3 h*emodia$filtration:ti,ab,kw
#4 (end-stage renal or end-stage kidney or endstage renal or endstage kidney):ti,ab,kw
#5 (ESRF or ESKF or ESRD or ESKD):ti,ab,kw
#6 (chronic kidney or chronic renal):ti,ab,kw
#7 (CKF or CKD or CRF or CRD):ti,ab,kw
#8 (CAPD or CCPD or APD):ti,ab,kw
#9 (predialysis or pre-dialysis):ti,ab,kw
#10 MeSH descriptor Kidney Failure, Chronic, this term only
#11 MeSH descriptor Renal Replacement Therapy explode all trees
#12 MeSH descriptor Renal Insufficiency, Chronic, explode all trees
#13 ((#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12)
#14 MeSH descriptor Diabetes Mellitus, this term only
#15 MeSH descriptor Diabetes Mellitus, Type 1 explode all trees
#16 MeSH descriptor Diabetes Mellitus, Type 2 explode all trees
#17 MeSH descriptor Diabetic Nephropathies explode all trees
#18 diabet*:ti,ab,kw
#19 (niddm or iddm):ab,ti,kw
#20 (#14 OR #15 OR #16 OR #17 OR #18 OR #19)
#21 (#13 AND #20)
#22 MeSH descriptor Hypoglycemic Agents explode all trees
#23 MeSH descriptor Sulfonylurea Compounds explode all trees
#24 MeSH descriptor Dipeptidyl-Peptidase IV Inhibitors, this term only
#25 MeSH descriptor Glucagon-Like Peptide 1, this term only
#26 MeSH descriptor alpha-Glucosidases, this term only
#27 MeSH descriptor Sodium-Glucose Transporter 2, this term only
#28 (glucose lowering and (therap* or agent* or drug*)):ti,ab,kw
in Clinical Trials
#29 (hypoglycemi* and (agent* or drug* or therap*)):ti,ab,kw
in Clinical Trials
#30 (antidiabet* and (agent* or drug* or therap*)):ti,ab,kw
in Clinical Trials
#31 (insulin*):ti,ab,kw in Clinical Trials
#32 (metformin):ti,ab,kw in Clinical Trials
#33 (Rosiglitazone):ti,ab,kw or (Rivoglitazone):ti,ab,kw or
(Pioglitazone):ti,ab,kw or (Troglitazone):ti,ab,kw in Clinical Trials
Chapter 2.3. B. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), is maximal oral therapy better than starting/adding insulin in an earlier stage?

MEDLINE search strategy
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (haemodiafiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. or/1-14
16. exp diabetes mellitus/
17. exp Diabetes Mellitus, Type 1/
18. exp Diabetes Mellitus, Type 2/
19. Diabetic Nephropathies/
20. diabet$.tw.
21. (niddm or iddm).tw.
22. or/16-21
23. 15 and 22
24. exp Hypoglycemic Agents/
25. (glucose lowering and (therap$ or agent$ or drug$)).tw.
26. (hypoglycemic and (agent$ or drug$ or therap$)).tw.
27. (antidiabet$ and (agent$ or drug$ or therap$)).tw.
28. metformin.tw.
29. Thiazolidinediones/
30. Rosiglitazone.tw.
31. Rivoglitazone.tw.
32. Pioglitazone.tw.
33. Troglitazone.tw.
34. glitazone$.tw.
35. exp Sulfonylurea Compounds/
36. (acarbose or miglitol or voglibose).tw.
37. Alogliptin.tw.
38. Linagliptin.tw.
39. (repaglinide or nateglinide or exenatide or pramlintide or benfluorex or liraglutide or mitiglinide):ti,ab,kw in Clinical Trials
40. (sitagliptin or vildagliptin or saxagliptin):ti,ab,kw in Clinical Trials
41. (Linagliptin):ti,ab,kw or (Alogliptin):ti,ab,kw in Clinical Trials
42. Dipeptidyl-Peptidase IV Inhibitors/
43. “glucagon-like peptide-1”:ti,ab,kw in Clinical Trials
44. (Incretin mimetic*):ti,ab,kw in Clinical Trials
45. (alpha-glucosidase inhibitor*):ti,ab,kw in Clinical Trials
46. Sodium-Glucose Transporter 2/
47. Sodium glucose co-transporter 2 inhibitor$.tw.
48. (repaglinide or nateglinide or exenatide or pramlintide or benfluorex or liraglutide or mitiglinide).tw.
49. (sitagliptin or vildagliptin or saxagliptin).tw.
50. exenatide.tw.
51. or/24-50
52. exp Insulins/
53. insulin$.tw.
54. or/52-53
55. 51 and 54
56. 55 and 23
57. randomized controlled trial.pt.
58. controlled clinical trial.pt.
59. randomized.ab.
60. placebo.ab.
61. clinical trials as topic/
62. randomly.ab.
63. trial.ti.
64. or/57-63
66. exp Technology Assessment, Biomedical/
67. exp Meta-analysis/
68. exp Meta-analysis as topic/
69. (health technology adj6 assessment$).tw,ot.
70. hta.tw,ot.
71. (meta analy$ or metaanaly$ or meta?analy$).tw,ot.
72. exp Cohort studies/
73. Incidence.tw.
74. exp mortality/
75. exp follow-up studies/
76. mo.fs.
77. prognos$.tw.
78. predict$.tw.
79. course.tw.
80. exp survival analysis/
81. or/65-80
82. (comment or editorial or historical-article).pt.
83. 81 not 82
84. 64 or 83
85. 56 and 84
86. animals/ not (humans/ and animals/) Index Medicus search strategy
#12 (acarbose or miglitol or voglibose).tw.
#13 (repaglinide or nateglinide or exenatide or pramlintide or benfluorex or liraglutide or mitiglinide).tw.
#14 (sitagliptin or vildagliptin or saxagliptin):ti,ab,kw in Clinical Trials
#15 (Linagliptin):ti,ab,kw or (Alogliptin):ti,ab,kw in Clinical Trials
#16 “glucagon-like peptide-1”:ti,ab,kw in Clinical Trials
#17 (Incretin mimetic*):ti,ab,kw in Clinical Trials
#18 (alpha-glucosidase inhibitor*):ti,ab,kw in Clinical Trials
#19 Na-Sulfonylureas/
#20 Na-glucosidase inhibitor$.tw.
#21 Sodium-Glucose Transporter 2/
#22 Sodium glucose co-transporter 2 inhibitor$.tw.
#23 (repaglinide or nateglinide or exenatide or pramlintide or benfluorex or liraglutide or mitiglinide).tw.
#24 (sitagliptin or vildagliptin or saxagliptin).tw.
#25 exenatide.tw.
#26 or/22-25
#27 exp Insulins/
#28 insulin$.tw.
#29 or/27-28
#30 #26 and #27
#31 randomized controlled trial.pt.
#32 controlled clinical trial.pt.
#33 randomized.ab.
#34 placebo.ab.
#35 clinical trials as topic/
#36 randomly.ab.
#37 trial.ti.
#38 or/31-37
#39 Meta-analysis.pt.
#40 exp Technology Assessment, Biomedical/
#41 exp Meta-analysis/
#42 exp Meta-analysis as topic/
#43 (health technology adj6 assessment$).tw,ot.
#44 hta.tw,ot.
#45 (meta analy$ or metaanaly$ or meta?analy$).tw,ot.
#46 exp Cohort studies/
#47 Incidence.tw.
#48 exp mortality/
#49 exp follow-up studies/
#50 mo.fs.
#51 prognos$.tw.
#52 predict$.tw.
#53 course.tw.
#54 exp survival analysis/
#55 or/46-54
#56 (comment or editorial or historical-article).pt.
#57 56 not 56
#58 52 or 53
#59 51 and 52
#60 50 and 51
#61 49 or 50
#62 48 or 49
#63 47 or 48
#64 46 or 47
#65 45 or 46
#66 44 or 45
#67 43 or 44
#68 42 or 43
#69 41 or 42
#70 40 or 41
#71 #29 and #70
#72 #19 and #71
#73 #17 and #72
#74 #15 and #73
#75 #13 and #74
#76 #11 and #75
#77 #9 and #76
#78 #7 and #77
#79 #5 and #78
#80 #3 and #79
#81 #1 and #80
#82 81 not 82
#83 82 not 83
#84 83 not 84
#85 84 not 85
#86 85 not 86

COCHRANE CENTRAL search strategy
#1 dialysis:ti,ab,kw
#2 h*emofiltration:ti,ab,kw
Chapter 3.1. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) and CAD, is PCI or CABG or conservative treatment to be preferred?

MEDLINE search strategy
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (haemofiltration or haemofiltration).tw.
8. (haemofiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. or/1-14
16. exp diabetes mellitus/
17. exp Diabetes Mellitus, Type 1/
18. exp Diabetes Mellitus, Type 2/
19. Diabetic Nephropathies/
20. diabet$.tw.
21. (niddm or iddm).tw.
22. or/16-21
23. exp coronary disease/
24. exp myocardial infarction/
25. exp angina pectoris/
26. coronary.tw.
27. angina.tw.
28. myocardial infarction.tw.
29. heart infarct$.tw.
30. (cardiac adj5 ischemia).tw.
32. myocardial infarct$.tw.
33. (cardiac adj5 ischemia).tw.
34. or/23-33
35. exp Coronary Artery Bypass/
36. coronary artery bypass$.tw.
37. CABG.tw.
38. exp Coronary Angiography/
39. exp Angioplasty, Balloon/
40. percutaneous coronary intervention$.tw.
Chapter 3.2. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) and with a cardiac indication (heart failure, ischaemic heart disease, hypertension), should we prescribe inhibitors of the RAAS system or aldosteron antagonists as cardiovascular prevention?

**MEDLINE search strategy**

1. Diabetes Mellitus/
2. exp Diabetes Mellitus, Type 1/
3. exp Diabetes Mellitus, Type 2/
4. Diabetic Nephropathies/
5. diabet$.tw.
6. (niddm or iddm).tw.
7. or/1-6
8. Kidney Diseases/
9. exp Renal Replacement Therapy/
10. #12 MeSH descriptor Renal Insufficiency, Chronic explode all trees
11. (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12)
12. #14 MeSH descriptor Diabetes Mellitus, this term only
13. #15 MeSH descriptor Diabetes Mellitus, Type 1 explode all trees
14. #16 MeSH descriptor Diabetes Mellitus, Type 2 explode all trees
15. #17 MeSH descriptor Diabetic Nephropathies explode all trees
16. #18 diabet*:ti,ab,kw
17. #19 (niddm or iddm):ab,ti,kw
18. #20 (#14 OR #15 OR #16 OR #17 OR #18 OR #19)
19. #21 (#13 AND #20)
20. #22 MeSH descriptor Coronary Disease, this term only
21. #23 MeSH descriptor Myocardial Infarction, this term only
22. #24 MeSH descriptor Angioplasty explode all trees
23. #25 coronary:ti,ab,kw
24. #26 anginat:ti,ab,kw
25. #27 MeSH descriptor Myocardial Ischemia explode all trees
26. #28 (#22 OR #23 OR #24 OR #25 OR #26 OR #27)
27. #29 MeSH descriptor Coronary Artery Bypass explode all trees
28. #30 MeSH descriptor Angioplasty explode all trees
29. #31 MeSH descriptor Stents explode all trees
30. #32 CABG:ti,ab,kw
31. #33 p.ci:ti,ab,kw
32. #34 p.tca:ti,ab,kw
33. #35 stent*:ti,ab,kw
34. #36 (coronary near bypass*):ti,ab,kw
35. #37 (myocard* near revascular*):ti,ab,kw
36. #38 (heart near revascular*):ti,ab,kw
37. #39 MeSH descriptor Coronary Angiography explode all trees
38. #40 MeSH descriptor Angioplasty, Balloon, Coronary, this term only
39. #41 (#29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40)
40. #42 (#21 AND #41)
10. Renal Insufficiency/
11. exp Renal Insufficiency, Chronic/
12. dialysis.tw.
13. (haemodialysis or haemodialysis).tw.
14. (haemofiltration or haemofiltration).tw.
15. (haemodiafiltration or haemodiafiltration).tw.
16. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
17. (ESRF or ESKF or ESRD or ESKD).tw.
18. (chronic kidney or chronic renal).tw.
19. (CKF or CKD or CRF or CRD).tw.
20. (CAPD or CCPD or APD).tw.
21. (predialysis or pre-dialysis).tw.
22. or/8-21
23. Coronary Disease/
24. Coronary Artery Disease/
25. Coronary Stenosis/
27. coronary stenos$tw.
28. coronary atheroscleros$.tw.
29. coronary arterioscleros$.tw.
31. CAD.tw.
32. exp Myocardial Ischemia/
33. exp Myocardial Revascularization/
34. (isch?emi$ adj3 heart).tw.
35. angina.tw.
36. myocardial infarct$.tw.
37. heart infarct$.tw.
38. (cardiac adj5 ischemia).tw.
39. exp stents/
40. stent$.tw.
41. exp Coronary Artery Bypass/
42. (coronary adj4 bypass$).tw.
43. cabg.tw.
44. pci.tw.
45. heart failure.tw.
46. cardiac failure.tw.
47. exp Heart Failure/
48. or/23-47
49. exp Aldosterone Antagonists/
50. Canrenoate Potassium.tw.
51. Canrenone$.tw.
52. spirinolactone$.tw.
53. aldosterone antagonist$.tw.
54. aldactone$.tw.
55. practon$.tw.
56. sc-9420$.tw.
57. spiractin$.tw.
58. sc-14266$.tw.
59. soldactone$.tw.
60. aldadiene$.tw.
61. phanurane$.tw.
62. sc-9376.tw.
63. eplerenone$.tw.
64. or/49-63
65. exp angiotensin converting enzyme inhibitors/
66. captopril.tw.
67. enalapril.tw.
68. cilazapril.tw.
69. enalaprilat.tw.
70. fosinopril.tw.
71. lisinopril.tw.
72. perindopril.tw.
73. ramipril.tw.
74. saralasin.tw.
75. teprotide.tw.
76. exp losartan/
77. losartan.tw.
78. imidazole$.tw.
79. irbesartan.tw.
80. candesartan.tw.
81. eprosartan.tw.
82. valsartan.tw.
83. olmesartan.tw.
84. telmisartan.tw.
85. (ace adj2 inhibitor$).tw.
86. (angiotensin adj2 receptor antagonist$).tw.
87. or/65-86
88. 64 or 87
89. 7 and 22 and 48 and 88

COCHRANE CENTRAL search strategy
#1 dialysis:ti,ab,kw
#2 h*emofiltro:ti,ab,kw
#3 h*emodialfiltration:ti,ab,kw
#4 (end-stage renal or end-stage kidney or endstage renal or endstage kidney):ti,ab,kw
#5 (ESRF or ESKF or ESRD or ESKD):ti,ab,kw
#6 (chronic kidney or chronic renal):ti,ab,kw
#7 (CKF or CKD or CRF or CRD):ti,ab,kw
#8 (CAPD or CCPD or APD):ti,ab,kw
#9 (predialysis or pre-dialysis):ti,ab,kw
#10 MeSH descriptor: [Kidney Failure, Chronic] this term only
#11 MeSH descriptor: [Renal Replacement Therapy] explode all trees
#12 MeSH descriptor: [Renal Insufficiency, Chronic] explode all trees
#13 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10
#14 MeSH descriptor: [Diabetes Mellitus] this term only
#15 MeSH descriptor: [Diabetes Mellitus, Type 1] explode all trees
#16 MeSH descriptor: [Diabetes Mellitus, Type 2] explode all trees
#17 MeSH descriptor: [Diabetic Nephropathies] explode all trees
#18 (niddm or iddm):ab,ti,kw
#19 (predialysis or pre-dialysis):ti,ab,kw
#20 (#14 or #16 or #17 or #18 or #19) #21 #13 and #20
#22 MeSH descriptor: [Aldosterone Antagonists] explode all trees
#23 MeSH descriptor: [Angiotensin-Converting Enzyme Inhibitors] explode all trees
Chapter 3.3. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we prescribe beta blockers to prevent sudden cardiac death?

**MEDLINE search strategy**
1. Diabetes Mellitus/
2. exp Diabetes Mellitus, Type 1/
3. exp Diabetes Mellitus, Type 2/
4. Diabetic Nephropathies/
5. diabet$tw.
6. (niddm or iddm).tw.
7. or/1-6
8. Kidney Diseases/
9. exp Renal Replacement Therapy/
10. Renal Insufficiency/
11. exp Renal Insufficiency, Chronic/
12. dialysis.tw.
13. (haemodialysis or haemodialysis).tw.
14. (hemofiltration or haemofiltration).tw.
15. (haemodiafiltration or haemodiafiltration).tw.
16. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
17. (ESRF or ESKF or ESRD or ESKD).tw.
18. (chronic kidney or chronic renal).tw.
19. (CKF or CKD or CRF or CRD).tw.
20. (CAPD or CCPD or APD).tw.
21. (predialysis or pre-dialysis).tw.
22. or/8-21
23. exp adrenergic beta-antagonists/
24. alprenolol.tw.
25. atenolol.tw.
26. metoprolol.tw.
27. nadolol.tw.
28. oxprenolol.tw.
29. pindolol.tw.
30. propranolol.tw.
31. exp adrenergic alpha-antagonists/
32. labetalol.tw.
33. prazosin.tw.
34. beta block$.tw.
35. or/23-34
36. 7 and 22 and 35

**COCHRANE CENTRAL search strategy**
1. dialysis:ti,ab,kw
2. h*emofiltration:ti,ab,kw
3. h*emodiafiltration:ti,ab,kw
4. (end-stage renal or end-stage kidney or endstage renal or endstage kidney):ti,ab,kw
5. (ESRF or ESKF or ESRD or ESKD):ti,ab,kw
6. (chronic kidney or chronic renal):ti,ab,kw
7. (CKF or CKD or CRF or CRD):ti,ab,kw
8. (CAPD or CCPD or APD):ti,ab,kw
9. (predialysis or pre-dialysis):ti,ab,kw
10. MeSH descriptor: [Kidney Failure, Chronic] this term only
11. MeSH descriptor: [Renal Replacement Therapy] explode all trees
12. MeSH descriptor: [Renal Insufficiency, Chronic] explode all trees
13. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10
14. MeSH descriptor: [Diabetes Mellitus] this term only
15. MeSH descriptor: [Diabetes Mellitus, Type 1] explode all trees
16. MeSH descriptor: [Diabetes Mellitus, Type 2] explode all trees
17. MeSH descriptor: [Diabetic Nephropathies] explode all trees
18. diabetes*:ti,ab,kw
19. (niddm or iddm):ab,ti,kw
20. (#14 or #15 or #16 or #17 or #18 or #19)
21. #13 and #20
22. MeSH descriptor: [Adrenergic beta-Antagonists] explode all trees
23. MeSH descriptor: [Adrenergic alpha-Antagonists] explode all trees
Chapter 3.4. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we aim at lower blood pressure targets than in the general population?

A Cochrane review of sufficient quality was used to answer this question.

Chapter 3.5. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we prescribe lipid-lowering therapy in primary prevention?

MEDLINE search strategy

1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (haemodiafiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. or/1-14
16. diabetes mellitus/
17. exp Diabetes Mellitus, Type 1/
18. exp Diabetes Mellitus, Type 2/
19. Diabetic Nephropathies/
20. diabet$.tw.
21. (niddm or iddm).tw.
22. or/16-21
23. exp Hypolipidemic Agents/
24. exp hyperlipidemias/
25. lipid-lower$.tw.
26. hypercholesterol$.tw.
27. antilipid$.tw.
28. hyperlipemia.tw.
29. hyperlipid$.tw.
30. dyslipemia.tw.
31. cholesterol-lower$.tw.
32. hydroxymethylglutaryl-coa reductase inhibitor*.tw.
33. HMG-CoA reductase inhibitor*.tw.
34. fibrate$.tw.
35. statin*.tw.
36. fluvastatin.tw.
37. simvastatin.tw.
38. pravastatin.tw.
39. lovastatin.tw.
40. meglutol.tw.
41. cerivastatin.tw.
42. atorvastatin.tw.
43. mevacor.tw.
44. pravachol.tw.
45. lescol.tw.
46. lipitor.tw.
47. cholestyramine.tw.
48. colestipol.tw.
49. gemfibrozil.tw.
50. $ibrate.tw.
51. clofibrate.tw.
52. ezetimibe.tw.
53. nicotinic acid.tw.
54. or/23-53
55. 15 and 22 and 54
56. randomized controlled trial.pt.
57. controlled clinical trial.pt.
58. randomi$ed.ab,ti.
59. placebo$.ab,ti.
60. drug therapy.fs.
61. randomly.ab,ti.
62. trial$.ab,ti.
63. group$.ab,ti.
64. or/56-63
66. exp Technology Assessment, Biomedical/
67. exp Meta-analysis/
68. exp Meta-analysis as topic/
69. (health technology adj6 assessment$).tw,ot.
70. hta.tw,ot.
71. (meta analy$ or metaanaly$ or meta?analy$).tw,ot.
72. exp Cohort studies/
73. Incidence.tw.
74. exp mortality/
75. exp follow-up studies/
76. mo.fs.
77. prognos$.tw.
78. predict$.tw.
79. course.tw.
80. exp survival analysis/
81. or/65-80
82. (comment or editorial or historical-article).pt.
83. 81 not 82
84. 81 or 82
85. 81 or 82
86. exp animal/ not humans/
87. 85 not 86

COCHRANE CENTRAL search strategy

#1 dialysis:ti,ab,kw
#2 h*emofiltration:ti,ab,kw
Chapter 3.6. A. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we recommend interventions aimed at increasing energy expenditure and physical activity?

MEDLINE
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (haemodiafiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. or/1-14
16. exp diabetes mellitus/
17. exp Diabetes Mellitus, Type 1/
18. exp Diabetes Mellitus, Type 2/
19. Diabetic Nephropathies/
20. diabet$.tw.
21. (niddm or iddm).tw.
22. or/16-21
23. Physical Exertion/
24. exp Exercise Therapy/
25. exp Exercise Test/
26. exp Physical Fitness/
27. exercise.tw.
28. (resistance training or resistance program$).tw.
29. (physical fitness or physical rehabilitation).tw.
30. (strength$ and (muscle or program$ or training$)).tw.
31. (Physical and (Education or Training$)).tw.
32. or/23-31
33. 15 and 22 and 32
34. exp animal/ not humans/
35. 33 not 34

COCHRANE CENTRAL
#1 dialysis:ti,ab,kw
#2 h*emofiltration:ti,ab,kw
#3 h*emodiafiltration:ti,ab,kw
#4 (end-stage renal or end-stage kidney or endstage renal or endstage kidney):ti,ab,kw
#5 (ESRF or ESKF or ESRD or ESKD):ti,ab,kw
#6 (chronic kidney or chronic renal):ti,ab,kw
#7 (CKF or CKD or CRF or CRD):ti,ab,kw
#8 (CAPD or CCPD or APD):ti,ab,kw
#9 (predialysis or pre-dialysis):ti,ab,kw
#10 MeSH descriptor Kidney Failure, Chronic, this term only
#11 MeSH descriptor Renal Replacement Therapy explode all trees
#12 MeSH descriptor Renal Insufficiency, Chronic explode all trees
#13 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12)
#14 MeSH descriptor Diabetes Mellitus, this term only
#15 MeSH descriptor Diabetes Mellitus, Type 1 explode all trees
#16 MeSH descriptor Diabetes Mellitus, Type 2 explode all trees
Chapter 3.6. B. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we recommend interventions aimed at reducing energy intake?

MEDLINE
1. Kidney Diseases/
2. exp Renal Replacement Therapy/
3. Renal Insufficiency/
4. exp Renal Insufficiency, Chronic/
5. dialysis.tw.
6. (haemodialysis or haemodialysis).tw.
7. (hemofiltration or haemofiltration).tw.
8. (haemofiltration or haemodiafiltration).tw.
9. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
10. (ESRF or ESKF or ESRD or ESKD).tw.
11. (chronic kidney or chronic renal).tw.
12. (CKF or CKD or CRF or CRD).tw.
13. (CAPD or CCPD or APD).tw.
14. (predialysis or pre-dialysis).tw.
15. or/1-14
16. exp diabetes mellitus/
17. exp Diabetes Mellitus, Type 1/
18. exp Diabetes Mellitus, Type 2/
19. Diabetic Nephropathies/
20. diabet$.tw.
21. (niddm or iddm).tw.
22. or/16-21
23. energy intake/
24. exp Diet Therapy/
25. exp Feeding Behavior/
26. exp Diet/
27. nutrition*.tw.
28. (nutri$ or diet$ or food or eat$).tw.
29. or/23-28
30. 15 and 22
31. 29 and 30
32. limit 31 to human
33. randomized controlled trial.pt.
34. controlled clinical trial.pt.
35. randomized.ab.

Chapter 3.7. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should antiplatelet therapy be recommended, regardless of their cardiovascular risk?

MEDLINE
1. exp Platelet Aggregation Inhibitors/
2. exp Phosphodiesterase Inhibitors/
3. Adenosine Diphosphate/ [Antagonists & Inhibitors]
4. Platelet Glycoprotein GPIIb-IIIa Complex/ [Antagonists & Inhibitors]
5. Sulfinpyrazone/
6. (antiplatelet agents$ or anti-platelet agent$).tw.
7. (antiplatelet therap$ or anti-platelet therap$).tw.
8. platelet aggregation inhibit$.tw.
9. phosphodiesterase inhibit$.tw.
10. thrombocyte aggregation inhibit$.tw.
11. (antithrombocytic agent$ or anti-thrombocytic agent$).tw.
12. (antithrombocytic therap$ or anti-thrombocytic therap$).tw.
13. alprostadil.tw.
14. aspirin.tw.
15. acetylsalicylic acid.tw.
16. (adenosine reuptake inhibit$ or adenosine re-uptake inhibit$).tw.
17. adenosine diphosphate receptor inhibit$.tw.
18. dipyridamole.tw.
19. disintegrins.tw.
20. epoprostenol.tw.
21. iloprost.tw.
22. ketanserin.tw.
23. milrinone.tw.
24. pentoxifylline.tw.
25. (S-nitrosoglutathione):ti,ab,kw
26. S-nitrosothiols:ti,ab,kw
27. trapidil.tw.
28. ticlopidine.tw.
29. clopidogrel.tw.
30. (sulfinpyrazone or sulphinpyrazone):ti,ab,kw
31. cilostazol.tw.
32. (P2Y12 NEAR/2 antagonis*):ti,ab,kw
33. prasugrel.tw.
34. ticagrelor.tw.
35. cangrelor.tw.
37. abciximab.tw.
38. eptifibatide.tw.
39. tirofiban.tw.
40. defibrotide.tw.
41. picotamide.tw.
42. beraprost.tw.
43. ticlid.tw.
44. aggrenox.tw.
45. ditazole.tw.
46. or/1-46
47. exp Renal Dialysis/
48. (haemodialysis or haemodialysis).tw.
49. (hemofiltration or haemofiltration).tw.
50. (haemodiafiltration or haemodiafiltration).tw.
51. dialysis.tw.
52. (PD or CAPD or CCPD or APD).tw.
53. Renal Insufficiency/
54. Kidney Failure/
55. exp Renal Insufficiency, Chronic/
56. Kidney Diseases/
57. Uremia/
58. (end-stage renal or end-stage kidney or endstage renal or endstage kidney).tw.
59. (ESRF or ESKF or ESRD or ESKD).tw.
60. (chronic kidney or chronic renal).tw.
61. (CKF or CKD or CRF or CRD).tw.
62. (predialysis or pre-dialysis).tw.
63. ur?emi$.tw.
64. or/48-64
65. and/47,65
66. and/47,65
67. exp diabetes mellitus/
68. exp Diabetes Mellitus, Type 1/
69. exp Diabetes Mellitus, Type 2/
70. Diabetic Nephropathies/
71. diabet$.tw.
72. (niddm or iddm).tw.
73. or/67-72
74. 73 and 66

COCHRANE CENTRAL

#1. MeSH descriptor Phosphodiesterase Inhibitors explode all trees
#2. MeSH descriptor Adenosine Diphosphate, this term only with qualifier: AI
#3. MeSH descriptor Platelet Glycoprotein GPIIb-IIIa Complex, this term only with qualifier: AI
#4. ((antiplatelet next agent*) or (anti-platelet next agent*)):ti,ab,kw
#5. ((antiplatelet therap*) or (anti-platelet therap*)):ti,ab,kw
#6. (platelet next aggregation next inhibit*):ti,ab,kw
#7. (phosphodiesterase next inhibit*):ti,ab,kw
#8. (thrombocyte next aggregation next inhibit*):ti,ab,kw
#9. ((antithrombocytic next agent*) or (anti-thrombocytic next agent*)):ti,ab,kw
#10. ((antithrombocytic next therap*) or (anti-thrombocytic next therap*)):ti,ab,kw
#11. alprostadil:ti,ab,kw
#12. aspirin:ti,ab,kw
#13. acetylsalicylic acid:ti,ab,kw
#14. ((adenosine next reuptake inhibit*) or (adenosine re-uptake inhibit*)):ti,ab,kw
#15. (adenosine diphosphate next receptor next inhibit*):ti,ab,kw
#16. dipyridamole:ti,ab,kw
#17. disintegrin:ti,ab,kw
#18. epoprostenol:ti,ab,kw
#19. iloprost:ti,ab,kw
#20. ketanserin:ti,ab,kw
#21. milrinone:ti,ab,kw
#22. pentoxifylline:ti,ab,kw
#23. (S-nitrosogluthathione):ti,ab,kw
#24. S-nitrosothiols:ti,ab,kw
#25. trapidil:ti,ab,kw
#26. ticlopidine:ti,ab,kw
#27. clopidogrel:ti,ab,kw
#28. (sulfinpyrazone or sulphinpyrazone):ti,ab,kw
#29. cilostazol:ti,ab,kw
#30. (P2Y12 NEAR/2 antagonis*):ti,ab,kw
#31. prasugrel:ti,ab,kw
#32. ticagrelor:ti,ab,kw
#33. cangrelor:ti,ab,kw
#34. glycoprotein IIB/IIIA inhibitors.tw.
#35. abciximab.tw.
#36. eptifibatide.tw.
#37. tirofiban.tw.
#38. defibrotide.tw.
#39. picotamide.tw.
APPENDIX 4. SELECTION OF STUDY FLOW CHARTS

Chapter 1.1. Should patients with diabetes and CKD stage 5 start with peritoneal dialysis or HD as a first modality?

Chapter 1.2. Should patients with diabetes and CKD stage 5 start dialysis earlier, i.e. before becoming symptomatic, than those without?

Chapter 1.3. In patients with diabetes and CKD stage 5, should a native fistula, a graft or a tunnelled catheter be preferred as initial access?

Chapter 1.4. What is the benefit of renal transplantation for dialysis patients with diabetes and CKD stage 5? C. Is there evidence for a selection bias in observational studies?
Chapter 1.4. C. Is there a benefit of renal transplantation for patients with diabetes and CKD stage 5?

Chapter 2.1. E. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we aim to lower HbA1C by tighter glycaemic control?

No flowchart available. Evidence extracted from the Cochrane Review written by Hemmingsen et al. [93].

Chapter 2.1. F. Is an aggressive treatment strategy (in number of injections and controls and follow up) superior to a more relaxed treatment strategy in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) and using insulin?

Chapter 2.2. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), are there better alternatives than HbA1C to estimate glycaemic control?

No flowchart available. All the included studies are listed in the narrative review from NDT: Are there better alternatives than haemoglobin A1c to estimate glycaemic control in the chronic kidney disease population? Nephrol Dial Transplant 2014; doi:10.1093/ndt/gfu006

Chapter 2.3. B. Is any oral drug superior to another in terms of mortality/complications/glycaemic control in patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²)?

Review of systematic reviews
Chapter 2.3. B. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), is maximal oral therapy better than starting/adding insulin in an earlier stage?

Chapter 3.1. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) and CAD, is PCI or CABG or conservative treatment to be preferred?

Chapter 3.2. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) and with a cardiac indication (heart failure, ischaemic heart disease, hypertension), should we prescribe inhibitors of the RAAS system or aldosteron antagonists as cardiovascular prevention?

Chapter 3.3. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we prescribe beta blockers to prevent sudden cardiac death?

Chapter 3.4. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we aim at lower blood pressure targets than in the general population?

A Cochrane review of sufficient quality was used to answer this question.

Chapter 3.5. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we prescribe lipid-lowering therapy in primary prevention?
Chapter 3.6

C. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we recommend interventions aimed at increasing energy expenditure and physical activity?

D. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we recommend interventions aimed at reducing energy intake?

Chapter 3.7. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should antiplatelet therapy be recommended, regardless of the cardiovascular risk?
Chapter 1.1. Should patients with diabetes and CKD stage 5 start with PD or HD as a first modality?

<table>
<thead>
<tr>
<th>Author</th>
<th>Publication Year</th>
<th>N HD</th>
<th>N PD</th>
<th>Outcome</th>
<th>Observation time</th>
<th>Effect Measure</th>
<th>Value</th>
<th>Confidence Interval</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
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<tbody>
<tr>
<td>Collins [226]</td>
<td>2002</td>
<td>26049</td>
<td>2805</td>
<td>Death rates per 1000 patient years</td>
<td>0–6 months</td>
<td>Relative risk</td>
<td>1.17</td>
<td>1.43</td>
<td>3.33</td>
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<tr>
<td>Collins [226]</td>
<td>2002</td>
<td>26049</td>
<td>2805</td>
<td>Death rates per 1000 patient years</td>
<td>6–12 months</td>
<td>Relative risk</td>
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<td>1.11</td>
<td>1.33</td>
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<tr>
<td>Ganesh [227]</td>
<td>2003</td>
<td>12905</td>
<td>1844</td>
<td>Death in patients with CAD</td>
<td>0–6 months</td>
<td>Relative risk</td>
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<td>Ganesh [227]</td>
<td>2003</td>
<td>28392</td>
<td>4651</td>
<td>Death in patients without CAD</td>
<td>0–6 months</td>
<td>Relative risk</td>
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<td>Ganesh [227]</td>
<td>2003</td>
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<td>4651</td>
<td>Death in patients without CAD</td>
<td>6–12 months</td>
<td>Relative risk</td>
<td>1.27</td>
<td>1.18</td>
<td>1.38</td>
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<tr>
<td>Ganesh [227]</td>
<td>2003</td>
<td>12905</td>
<td>1844</td>
<td>Death in patients with CAD</td>
<td>6–12 months</td>
<td>Relative risk</td>
<td>1.32</td>
<td>1.16</td>
<td>1.49</td>
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<tr>
<td>Liem [228]</td>
<td>2007</td>
<td>1615</td>
<td>928</td>
<td>Death in DM patients aged 40 years</td>
<td>3–6 months</td>
<td>Hazard ratio</td>
<td>0.10</td>
<td>0.23</td>
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<tr>
<td>Liem [228]</td>
<td>2007</td>
<td>1615</td>
<td>928</td>
<td>Death in DM patients aged 50 years</td>
<td>3–6 months</td>
<td>Hazard ratio</td>
<td>0.33</td>
<td>0.34</td>
<td>0.83</td>
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<td>2007</td>
<td>1615</td>
<td>928</td>
<td>Death in DM patients aged 60 years</td>
<td>3–6 months</td>
<td>Hazard ratio</td>
<td>0.71</td>
<td>0.48</td>
<td>1.04</td>
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<td>2007</td>
<td>1615</td>
<td>928</td>
<td>Death in DM patients aged 70 years</td>
<td>3–6 months</td>
<td>Hazard ratio</td>
<td>0.95</td>
<td>0.64</td>
<td>1.39</td>
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<tr>
<td>Stack [19]</td>
<td>2003</td>
<td>41316</td>
<td>6464</td>
<td>Death in diabetic patients with congestive heart failure</td>
<td>0–6 months</td>
<td>Relative risk</td>
<td>1.14</td>
<td>1.01</td>
<td>1.28</td>
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<td>41316</td>
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<td>Relative risk</td>
<td>0.93</td>
<td>0.82</td>
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<td>6464</td>
<td>Death in diabetic patients with congestive heart failure</td>
<td>6–12 months</td>
<td>Relative risk</td>
<td>1.33</td>
<td>1.20</td>
<td>1.46</td>
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<tr>
<td>Stack [19]</td>
<td>2003</td>
<td>41316</td>
<td>6464</td>
<td>Death in diabetic patients without congestive heart failure</td>
<td>6–12 months</td>
<td>Relative risk</td>
<td>1.31</td>
<td>1.16</td>
<td>1.49</td>
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<tr>
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<td>2002</td>
<td>951</td>
<td>274</td>
<td>Death in diabetic patients &gt; 65 years</td>
<td>0–3 months</td>
<td>Hazard ratio</td>
<td>NS</td>
<td></td>
<td></td>
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<tr>
<td>Winkelmayer [229]</td>
<td>2002</td>
<td>951</td>
<td>274</td>
<td>Death in diabetic patients &gt; 65 years</td>
<td>3–6 months</td>
<td>Relative risk</td>
<td>NS</td>
<td></td>
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<tr>
<td>Winkelmayer [229]</td>
<td>2002</td>
<td>951</td>
<td>274</td>
<td>Death in diabetic patients &gt; 65 years</td>
<td>9–12 months</td>
<td>Relative risk</td>
<td>NS</td>
<td></td>
<td></td>
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<tr>
<td>Weinhandl [17]</td>
<td>2010</td>
<td>3099</td>
<td>3086</td>
<td>Death in DM patients over 18 years</td>
<td>0–12 months</td>
<td>Hazard ratio</td>
<td>NS</td>
<td></td>
<td></td>
<td></td>
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<td>1615</td>
<td>928</td>
<td>Death in DM patients aged 40 years</td>
<td>0–3 months</td>
<td>Hazard ratio</td>
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<td>0.44</td>
<td>0.81</td>
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<td>Death in DM patients aged 70 years</td>
<td>6–15 months</td>
<td>Hazard ratio</td>
<td>1.07</td>
<td>0.85</td>
<td>1.33</td>
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<td>1615</td>
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<td>Death in DM patients aged 40 years</td>
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<td>Hazard ratio</td>
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<td>&gt;15 months</td>
<td>Hazard ratio</td>
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<td>Liem [228]</td>
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<td>Death in DM patients aged 60 years</td>
<td>&gt;15 months</td>
<td>Hazard ratio</td>
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<td>Death in DM patients aged 70 years</td>
<td>&gt;15 months</td>
<td>Hazard ratio</td>
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<td>1.23</td>
<td>1.65</td>
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<td>111</td>
<td>70</td>
<td>Death in diabetic patients aged &gt; 60 years</td>
<td>3–24 months</td>
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<td>0.40</td>
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<td>Termorshuizen [15]</td>
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<td>70</td>
<td>Death in diabetic patients aged &lt;60 years</td>
<td>3–24 months</td>
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Late mortality (>36 months)

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<td>0-5 years</td>
<td>Diabetic patients &lt;65 years</td>
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Hazard ratio or a relative risk higher than 1 (highlighted in red) indicates a higher mortality for PD patients. An HR lower than 1 (highlighted in green) indicates a higher mortality for HD patients.
**Chapter 1.2. Should patients with diabetes and CKD stage 5 start dialysis earlier, i.e. before becoming symptomatic, than patients without diabetes?**

<table>
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<tr>
<th>Study</th>
<th>Publication year</th>
<th>Design</th>
<th>Inclusion criteria</th>
<th>Patient characteristics</th>
<th>Intervention (n)</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
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<tr>
<td>Cooper et al. [29]</td>
<td>2010-2000-2008</td>
<td>Randomized controlled trial (IDEAL study)</td>
<td>- Patients were eligible for inclusion in the study if they had progressive CKD (patients with a failing kidney transplant were eligible) and an estimated GFR between 10.0 and 15.0 mL per minute per 1.73 m² - Exclusion: &lt;18 years of age, eGFR &lt;10.0 mL/min, planned living donation within 12 months, cancer that was likely to affect mortality</td>
<td>- Age: 60.3 years - Gender: 65% male - DM (as PRD): 34% - eGFR at start: 9.9 mL/min/1.73 m²</td>
<td>- Late start of dialysis group (eGFR &gt;7.5 mL) (n = 104)</td>
<td>- Mortality</td>
<td>HR 1.04 (0.83–1.30) P = 0.75. P for interaction for early or late start of dialysis with diabetes = 0.63</td>
<td>High</td>
<td>RCT with proper subgroup analysis for interaction in diabetics</td>
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<tr>
<td>Coronel et al. [33]</td>
<td>2009-1982-2004</td>
<td>Retrospective cohort study</td>
<td>- They had begun PD as the first renal replacement treatment, remained on the therapy for more than 2 months, and had sufficient parameters to measure the GFR by Modification of Diet in Renal Disease-7 (MDRD-7) [13], a currently validated method used to measure the GFR in diabetic CKD patients</td>
<td>- Age: 53 years - Gender: 65% male - DM = 100% - DM1 = 54% - PD = 100% - Median eGFR at start: 7.7 mL/min/1.73 m²</td>
<td>- eGFRMDRD, 5–7.5 mL (n = 99 940), 7.6–10 mL (n = 74 656), &gt;10 mL at start of dialysis (n = 76 046)</td>
<td>- Mortality (on PD in diabetics, in DM1 and in DM2)</td>
<td>- Hospital admissions (admissions/year and days of hospitalizations)</td>
<td>- KM higher actuarial mortality in eGFR &gt;7.7 mL group. P &lt;0.007 - KM: similar mortality in eGFR &gt;7.7 mL in DM2 group P = 0.045 - No difference in admissions per year between intervention and comparator group (i.e. 1.3 ± 1.0 versus 1.5 ± 1.2 admission/year P = NS) - No difference in number of days of hospitalization between intervention and comparator group (23.1 ± 29 versus 20 ± 22 days/patient/year)</td>
<td>Low</td>
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<tr>
<td>Kazmi et al. [34]</td>
<td>2005-1996-1999</td>
<td>Retrospective cohort study</td>
<td>- In principle all North American pts that start dialysis. The extent to which the ESRD Medical Evidence Form covers these pts is not mentioned - Patients with missing GFR values, acquired HIV virus, or cancer were excluded from this analysis</td>
<td>- Age: 62 years - Gender: 53% male - DM (PRD): 46% - DM (Comorbid): 48% - eGFR at start: 8.4 mL/min/1.73 m²</td>
<td>- eGFRMDRD 5–7.5 mL (n = 265)</td>
<td>- Mortality/mortality on dialysis in 1) whole population (fully adjusted)</td>
<td>- Hospital admissions (admissions/year and days of hospitalizations)</td>
<td>- KM higher actuarial mortality in eGFR &gt;7.7 mL group. P &lt;0.007 - KM: similar mortality in eGFR &gt;7.7 mL in DM1. P = 0.2 - KM higher actuarial mortality in eGFR &gt;7.7 mL in DM2 group P = 0.045 - No difference in admissions per year between intervention and comparator group (i.e. 1.3 ± 1.0 versus 1.5 ± 1.2 admission/year P = NS) - No difference in number of days of hospitalization between intervention and comparator group (23.1 ± 29 versus 20 ± 22 days/patient/year)</td>
<td>Low</td>
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<tr>
<td>Lassalle et al. [35]</td>
<td>2010-2002-2006</td>
<td>Retrospective cohort study</td>
<td>- The REIN Registry includes all ESRD patients on renal replacement therapy, either dialysis or transplantation, treated in France - Patients with acute kidney failure are excluded, that is, those who recover all or some renal function within 45 days or who die before 45 days and are diagnosed with acute kidney failure by experts</td>
<td>- Age: 67 years - Gender: 62% male - DM (PRD): 21.2% - DM (Comorbid): 35.8% - eGFR at start: 8.8 mL/min/1.73 m²</td>
<td>- eGFRMDRD 5–10 mL (n = 6683), 10–15 mL (n = 2517), 15–20 mL (n = 633), &gt;20 mL at start of dialysis (n = 265)</td>
<td>- Mortality/ Mortality on dialysis (+ KM)</td>
<td>2) Access to transplant-ation</td>
<td>1) HR = 1.09 (1.05–1.14, P &lt;0.05). Mortality decreased strongly with increasing MDRD eGFR (Figure 3, log-rank P &lt;0.0001). Two-year mortality decreased from 79 to 46% for the lowest versus the highest eGFR levels 2) Of the patients who began dialysis with eGFR p5, 6–10, 11–15, 16–20, and 420 mL/min per 1.73 m², 21, 17, 8, 4, and 6%, respectively, received kidney transplants</td>
<td>Low</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>Setting</td>
<td>Study Design</td>
<td>Inclusion Criteria</td>
<td>Follow-up</td>
<td>Results</td>
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<tr>
<td>Tang et al. [31]</td>
<td>2007-2004 Asia</td>
<td>Prospective cohort study</td>
<td>All patients with chronic renal failure and their close relatives were invited</td>
<td>- Age: 58 years - Gender: 52% Male - DM2: 42% - eGFR at start in elective starters: 9.21 mL/min/1.73 m² - eGFR at start in initial refusers: 8.89 mL/min/1.73 m²</td>
<td>- Initial refusers (n = 82) - Elective starters (n = 151) - 1 year (5 years for outcome 'need for blood transfusion')</td>
<td>1) All-cause mortality, crude HR = 3.12 (1.34–9.40, P = 0.011) 2) All-cause mortality on dialysis (adjusted for MD, age, sex, eGFR) = 3.01 (1.32–9.40, P = 0.01) 3) Cardiovascular mortality = 2.6% versus 9.8% in initial refusers, P = 0.01 4) 2.13 ± 1.13 versus 3.14 ± 1.17 episodes/person/year in initial refusers, P = 0.05 5) 0.38 ± 0.07 versus 0.8 ± 0.35 episodes/person/year in initial refusers, P = 0.033</td>
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<tr>
<td>Traynor et al. [36]</td>
<td>2002-2003 Europe</td>
<td>Retrospective cohort study</td>
<td>Patients had to have started dialysis, first referral had to be with an eGFR ≥ 20 mL, the time between referral and start of dialysis had to be &gt;180 days</td>
<td>- Age: 53 years - Gender: 67% male - DM2: 21.7% - Median eGFR_CK at start: 10.4 (IQR: 9.1–11.9) in the early start group and 6.7 (IQR: 5.6–7.5) mL/min in the late start group</td>
<td>- Including diabetics - Late start eGFR_CK &lt; 8.3 mL/min (n = 116) - Early start eGFR ≥ 8.3 mL/min (n = 119) - Excluding diabetics - Late start eGFR &lt; 8.0 mL/min (n = 87) - Early start eGFR ≥ 8.0 mL/min (n = 97)</td>
<td>- Mortality/mortality on dialysis - HR = 0.89 (0.88–0.90, P &lt;0.06) versus eGFR</td>
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<tr>
<td>Wright et al. [37]</td>
<td>2010 North America</td>
<td>Retrospective cohort study</td>
<td>Incident dialysis patients aged &gt;18 years - Renal transplantation or renal function recover. Outliers in BMI, weight or height</td>
<td>- Age: 64.7 years - Gender: 53.1% - DM (PRD): 46.7% - DM (Comorbid): 56.2% - HD: 92.8% - sCr: 7.2 (3.5) mg/dL</td>
<td>- Dialysis started at eGFR_MDRD = 5 mL/min (n = 113 510) and dialysis started at eGFR &gt;15 mL/min (n = 99 231) - Dialysis started at eGFR &gt;5–10 -150 months</td>
<td>- Mortality/mortality at 60 months - HR = 1.11 (1.01–1.21, P = 0.024) Low</td>
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<tr>
<td>Jain et al. [41]</td>
<td>2014 North America</td>
<td>Retrospective cohort study</td>
<td>All incident PD patients (aged &gt;18 years at dialysis therapy initiation) who had a recorded value for serum creatinine at dialysis therapy initiation and who received PD as their first form of renal replacement therapy between 1 January 2001, and 31 December 2009</td>
<td>- Age: 60.9 - Male: 57.3% - DM (PRD): 36.2% - DM (comorbid): 42.9%</td>
<td>- Mid start of dialysis at eGFR &gt;10.5 mL/min (n = 2670) and early start at eGFR &gt;10.5 mL/min/1.73 m² (n = 2994)</td>
<td>- Mortality/mortality at 5 years - HR = 1.16 (0.82–1.63) for early versus late. - HR = 0.99 (0.70–1.39) for mid versus late Medioocre</td>
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<tr>
<td>Beddhu et al. [38]</td>
<td>2003 North America</td>
<td>Prospective cohort study</td>
<td>Incident chronic HD and PD patients who initiated dialysis therapy in 1996 and early 1997. - Patients with previous renal replacement therapy, duplicate entries, missing USRDS identification numbers, or missing follow-up data and patients younger than 18 years, missing data for age, sex, race</td>
<td>- Age: 59 - Male: 53% - Ethnicity: White 64% Black 28% - DM (PRD): 42% - HD: 53% - sCr: 8.2 ± 3.9 - sCr: 30.8 ± 5.4</td>
<td>- a 5 mL/min increase in eGFR_MDRD at start of dialysis (n = 2920) - 5585 patient-years of follow-up</td>
<td>- Mortality/mortality - HRadj = 1.14 (1.06 – 1.14) for every 5 mL/min increase in eGFR at start of dialysis Low</td>
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<table>
<thead>
<tr>
<th>Study</th>
<th>Publication year</th>
<th>Design</th>
<th>-Inclusion criteria</th>
<th>Patient characteristics</th>
<th>-Intervention (n)</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Clark et al. [40]</td>
<td>2011</td>
<td>North America -2001–2007</td>
<td>Retrospective cohort study</td>
<td>height, weight, blood urea nitrogen (BUN), serum creatinine, serum albumin, haematocrit, and serum bicarbonate were excluded. All adult (≥18 years) patients with a recorded serum creatinine value who started with HD as their first form of renal replacement therapy</td>
<td>BUN: 87 ± 31-Bicarbonate: 22.0 ± 4.6-BMI: 26.3 ± 5.8-Age: Early group: 67.5 (14.0), Late group: 63.7 (15.2)-Male: Early: 67%, Late: 56.4%-DM (PRD): Early: 40.6%, Late: 33.9%-DM (Comorbid): Early: 52.7%, Late: 43.4%</td>
<td>Early initiation of dialysis with eGFR&lt;sub&gt;MDRD&lt;/sub&gt; &lt; 10.5 mL/min/1.73 m&lt;sup&gt;2&lt;/sup&gt; (n = 8441) -Late start of dialysis with eGFR&lt;sub&gt;MDRD&lt;/sub&gt; ≤ 10.5 mL/min/1.73 m&lt;sup&gt;2&lt;/sup&gt; (n = 17 469)</td>
<td>Mortality/mortality: HR&lt;sub&gt;Adj&lt;/sub&gt; = 1.18 (1.13–1.23) for early initiation of dialysis compared with late initiation of dialysis</td>
<td>Mediocre</td>
<td>Retrospective cohort study in Canadian registry data with substantial adjustment for confounding although never sufficient to be absolutely sure benefits of late start are not a reflection of other factors</td>
</tr>
<tr>
<td>Harris et al. [210]</td>
<td>2011-2002–2008</td>
<td>Australia/New Zealand</td>
<td>RCT (IDEAL study)</td>
<td>Patients were eligible for inclusion in the study if they had progressive CKD (patients with a failing kidney transplant were eligible) and an estimated GFR between 10.0 and 15.0 mL per minute per 1.73 m&lt;sup&gt;2&lt;/sup&gt;; Patients could not be included in the study if they were younger than 18 years of age, had an estimated GFR of less than 10.0 mL per minute, had plans to receive a kidney transplant from a live donor within the next 12 months, had a recently diagnosed cancer that was likely to affect mortality, or were unable to provide written informed consent</td>
<td>Age: 60.0 ± 13.2, Late starters: 60.5 ± 12.1-Male: Early: 64%, Late: 64%-DM (PRD): Early: 33.2%, Late: 34.6%-DM (Comorbid): Early: 42%, Late: 43.6%</td>
<td>Late start of dialysis group (eGFR&lt;sub&gt;MDRD&lt;/sub&gt; between 5–7 mL) (n = 335). Early start of dialysis group (eGFR&lt;sub&gt;MDRD&lt;/sub&gt; between 10–14 mL) (n = 307)</td>
<td>Time to dialysis in early: 1.90 months, late: 7.30 months</td>
<td>QoL -QALY -Total cost of treatment: Difference in QoL between early- and late-start: −0.00 (−0.03; 0.03) QALY early: 1.97 (1.81–2.14) QALY late: 2.07 (1.92–2.21) Difference in QALY (adjusted for baseline AQoL): −0.09 (−0.12; 0.31) Early start group: $215 354 ($114 777–$311 713) versus Late start group: $202 124 ($114 636–$288 704)</td>
<td>High</td>
</tr>
<tr>
<td>Hwang et al. [39]</td>
<td>2010</td>
<td>Asia 2001–2004</td>
<td>Retrospective cohort study</td>
<td>Incident HD patients between July 2001 and December 2004; Patients with age ≥20 years, PD as primary treatment, incomplete ID digits, eGFR ≥15 mL/min/1.73 m&lt;sup&gt;2&lt;/sup&gt; at start of dialysis or mortality &lt;3 months (90 days)</td>
<td>Age: 61.5 ± 14.0-Male: 47.7%-DM (PRD): 42.9%eGFR&lt;sub&gt;MDRD&lt;/sub&gt;: 4.7 (3.6–6.1) mL/min/1.73 m&lt;sup&gt;2&lt;/sup&gt;-2nd quintile (eGFR&lt;sub&gt;MDRD&lt;/sub&gt; 3.29–4.27 mL/min/1.73 m&lt;sup&gt;2&lt;/sup&gt;) (n = 4749), 3rd quintile (eGFR&lt;sub&gt;MDRD&lt;/sub&gt; 4.28–5.20) (n = 4727), 4th quintile (eGFR&lt;sub&gt;MDRD&lt;/sub&gt; 5.21–6.51) (n = 4708), 5th quintile (eGFR&lt;sub&gt;MDRD&lt;/sub&gt; ≥6.52) (n = 4698)</td>
<td>-1st quintile (eGFR &lt;3.29) (n = 4669)</td>
<td>Follow-up: 22 291 patient years in 23 551 patients</td>
<td>Mortality/mortality: HR&lt;sub&gt;Gd&lt;/sub&gt; versus Q2: 1.18 (1.01–1.37) HR&lt;sub&gt;Gd&lt;/sub&gt; versus Q3: 1.21 (1.04–1.41) HR&lt;sub&gt;Gd&lt;/sub&gt; versus Q4: 1.66 (1.43–1.93) HR&lt;sub&gt;Gd&lt;/sub&gt; versus Q5: 2.44 (2.11–2.81)</td>
<td>Mediocre</td>
</tr>
</tbody>
</table>
### Chapter 1.3. In patients with diabetes and CKD stage 5, should a native fistula, a graft or a tunnelled catheter be preferred as initial access?

<table>
<thead>
<tr>
<th>Study</th>
<th>Publication year - Time frame - Location</th>
<th>Design</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
<th>Patient characteristics</th>
<th>Intervention (n) - Comparator (n) - Duration</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chan et al.</td>
<td>2007 - 1996 - North America</td>
<td>Retrospective cohort study</td>
<td>HD patients age 65 years and older, included in the DMMS Wave 2 study were eligible for inclusion into the study.</td>
<td>Subjects were excluded if PD was the recorded modality, a temporary or tunnelled catheter was used for HD at the time of the DMMS interview, and if the data necessary to conduct time to event analysis was missing</td>
<td>-43% diabetes</td>
<td>-AVG placement - AVF placement - 25 months - n = 462</td>
<td>Survival of the technique (patency rate) - Mortality</td>
<td>-OR 1.49 (0.76–2.89; P = 0.224) - OR 1.34 (0.92–1.95; P = 0.123)</td>
<td>Registry-based reporting of outcome - Incomplete adjustment for co-variates</td>
<td>Number of events not stated - Number of analysed participants in each study group not stated</td>
</tr>
<tr>
<td>David et al.</td>
<td>2010 - 2003-2008 - Europe</td>
<td>Retrospective cohort study</td>
<td>Incident HD patients referred to AVF placement</td>
<td>Age 67 ± 12 years - 26% diabetes</td>
<td>Proximal AVF placement (n = 38) - Distal AVF placement (n = 34) - 80 months</td>
<td>Survival of the technique (primary patency rate)</td>
<td>-55% -30%</td>
<td>Generalizability uncertain - Incomplete adjustment for co-variates</td>
<td>Centre bias</td>
<td>No valid outcome measures</td>
</tr>
<tr>
<td>Dhingra et al.</td>
<td>2001 - 1993-1995 - North America</td>
<td>Retrospective cohort study</td>
<td>Incident and prevalent HD patients. Patients were excluded if they were less than 15 years of age at the study start date had a functioning kidney transplant, were in training for any self-care treatment, or were receiving PD or home HD at the study start date</td>
<td>Age 59 years - Male gender: 51% - 31% diabetes</td>
<td>HD patients with AVG (n = 3129) and HD patients with CVC (n = 875). - HD patients with AVF (n = 1340) - 24 months</td>
<td>All-cause mortality - Cardiovascular-related mortality - Infection-related mortality</td>
<td>RR = 1.54, 1.17–2.02; RR = 1.41, 1.13–1.77; CVC versus AVF and AVG versus AVF, respectively</td>
<td>RR = 1.47, 1.00–1.16; RR = 1.35, 0.98–1.85, CVC versus AVF and AVG versus AVF, respectively</td>
<td>Registry-based reporting of outcome</td>
<td>Large population from the Master List of Medicare Approved Dialysis Facilities</td>
</tr>
<tr>
<td>Diehm et al.</td>
<td>2010 - Europe</td>
<td>Retrospective cohort study</td>
<td>All patients with successful access placement in the vascular access centre</td>
<td>-25% Diabetes</td>
<td>Diabetic patients (n = 62) - Nondiabetic patients (n = 182) - 24 months</td>
<td>Survival of the technique (primary and secondary patency rates)</td>
<td>-OR = 0.60 (0.30–1.00) - OR = 0.40 (0.20–0.70)</td>
<td>Generalizability uncertain - Selection bias - Center bias</td>
<td>No adjustment for covariates</td>
<td>Number of events not stated - No reliable data within the diabetic group</td>
</tr>
<tr>
<td>Field et al.</td>
<td>2008 - 2003–2007 - Europe</td>
<td>Retrospective cohort study</td>
<td>Incident HD patients with AVF</td>
<td>Age: 61 years - Male gender: 54% - 36% diabetes</td>
<td>Diabetic patients (n = 103) - Nondiabetic patients (n = 186) - 48 months</td>
<td>Survival of the technique (primary patency rate)</td>
<td>-34% versus 26% (P = 0.110)</td>
<td>Generalizability uncertain - Centre bias - No adjustment for confounders</td>
<td>Number of events not stated - No reliable data within the diabetic group</td>
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<tr>
<td>Hammes et al.</td>
<td>2008 - 2000–2007 - North America</td>
<td>Retrospective cohort study</td>
<td>HD patients who underwent vascular access angiography and had at least 1 follow-up venogram done as clinically indicated</td>
<td>-41% diabetes</td>
<td>Cephalic arch stenosis in diabetic patients with CVC (n = 27) and without CVC (n = 25) cephalic arch lesion</td>
<td>Survival of the technique (the number of weeks to the development of clinically)</td>
<td>-Mean difference: 114 ± 17 versus 109 ± 18</td>
<td>Generalizability uncertain - Center bias - Small patient</td>
<td>No baseline characteristics</td>
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<tr>
<th>Study</th>
<th>Design</th>
<th>Patient characteristics</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Konner et al. [238]</td>
<td>Retrospective cohort study</td>
<td>Age: 59 years - Diabetic patients (n = 78) - Nondiabetic patients (n = 269) - Duration: 72 months</td>
<td>Survival of the technique (median time to first event)</td>
<td>42.3 versus 45.8 months</td>
<td>Generalizability uncertain Centre bias No valid outcome measures No reliable data within the diabetic group</td>
<td></td>
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<tr>
<td>Konner et al. [50]</td>
<td>Retrospective cohort study</td>
<td>Age: 60 years - Male gender: 59% - Diabetic patients with proximal perforating vein (n = 86) and non-perforating vein (n = 52) AVF - Duration: 24 months</td>
<td>Survival of the technique (primary and secondary patency rates)</td>
<td>-80% versus 80% versus 50% -90% versus 80% versus 80%</td>
<td>Generalizability uncertain Centre bias Small patient numbers No valid outcome measures Descriptive outcome measures</td>
<td></td>
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<tr>
<td>Leapman et al. [52]</td>
<td>Retrospective cohort study</td>
<td>Age 50 ± 16 years - Male gender: 66% - Diabetic patients with forearm AVF (n = 43)</td>
<td>Survival of the technique (cumulative patency rate)</td>
<td>63% versus 42%</td>
<td>Generalizability uncertain Centre bias No valid outcome measures No reliable data within the diabetic group</td>
<td></td>
</tr>
<tr>
<td>Murphy et al. [51]</td>
<td>Retrospective cohort study</td>
<td>Age 60 years - Male gender: 65% - Diabetic patients - Nondiabetic patients</td>
<td>Survival of the technique (cumulative patency rate)</td>
<td>-39% versus 40% (P = N.S.)</td>
<td>Generalizability uncertain Centre bias No adjustment for confounders No reliable data within the diabetic group</td>
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<tr>
<td>Ravani et al. [43]</td>
<td>Prospective cohort study</td>
<td>-22% diabetes - Diabetic patients - Nondiabetic patients</td>
<td>Survival of the technique (primary and cumulative patency rate)</td>
<td>-HR = 1.85, P = 0.01 -HR = 2.38, P = 0.04</td>
<td>Generalizability uncertain Centre bias No adjustment for confounders Generalizability uncertain Centre bias No reliable data within the diabetic group</td>
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</tr>
<tr>
<td>Saxena et al. [44]</td>
<td>Prospective cohort study</td>
<td>-22% diabetes - Diabetic patients - Nondiabetic patients</td>
<td>Vascular access infection-related mortality</td>
<td>-15%, 42% (P &lt;0.0006), 33% (P &lt;0.03), 37.5% (P &lt;0.001), 100% (P &lt;0.0005)</td>
<td>Generalizability uncertain Centre bias No adjustment for confounders Small number of patients No reliable data within the diabetic group</td>
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<tr>
<td>Yeager et al. [54]</td>
<td>Retrospective case-control study</td>
<td>Male gender: 97% - 55% Diabetes</td>
<td>Survival rate</td>
<td>-49% versus 52% (P &gt; 0.05)</td>
<td>Generalizability uncertain Centre bias No adjustment for confounders Unbalance between the number of cases and controls No reliable data within the diabetic group</td>
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</table>
Chapter 1.4. What is the benefit of renal transplantation for dialysis patients with diabetes and CKD stage 5? C. Is there evidence for a selection bias in observational studies?

<table>
<thead>
<tr>
<th>Study</th>
<th>Population/Source/Aim</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Batabyal et al. [62] 2012</td>
<td>Published guidelines from 2001 to 2011 from Australia, Japan, Malaysia, South Africa, United Kingdom, United States, Continental Europe, and Canada. This study aimed to compare the quality, the scope, and the consistency of national and international clinical practice guidelines on waitlisting of patients for kidney transplantation.</td>
<td>Diabetes was not contraindicated unless associated with multiple organ failure or significant cardiovascular complications. Of the 10 guidelines discussing diabetes, 7 recommended simultaneous screening for cardiovascular disease. Almost all guidelines suggested simultaneous pancreas–kidney transplantation for patients with type 1 diabetes but did not recommend age thresholds.</td>
</tr>
<tr>
<td>Bayat et al. [239] 2008</td>
<td>NEPHROLOR database (all ESRD patients living in Lorraine and placed on the waiting list), n = 809.</td>
<td>Diabetes was an independent factor associated with non-registration on waiting list (OR 2.97; 95CI 1.67–5.28).</td>
</tr>
<tr>
<td>Dudley et al. [240] 2009</td>
<td>Cross-sectional study of 12 401 prevalent adult dialysis patients from 41 renal units across England and Wales. A total of 23.3% of patients were active on the transplant waiting list. Patients from the United States Renal Data System (January 1, 1990–September 1, 2007; n = 3407; 50.4% had diabetes) to study association between the Social Adaptability Index (SAI; based upon employment, marital status, education, income, and substance abuse) and outcomes (time to being placed on the waiting list and time to being transplanted once listed).</td>
<td>Patients with a primary renal diagnosis of diabetes mellitus were least likely to be on the active waiting list. (n = 1963; OR 0.30; 0.25–0.36). In patients with no history of diabetes (compared with history of diabetes) HR of being waitlisted is 1.19 (0.89–1.57) P = 0.238; HR of being transplanted 0.81 (0.61–1.07) P = 0.141.</td>
</tr>
<tr>
<td>Goldfarb-Rumyantsev et al. [241] 2011</td>
<td>Non-concurrent cohort study of 835 patients on the waiting list for kidney transplants from 2000 to 2004 to analyse factors associated with access to kidney transplants from living and cadaver donors in Belo Horizonte, Brazil.</td>
<td>Diabetes was not contraindicated unless associated with multiple organ failure or significant cardiovascular complications. Of the 10 guidelines discussing diabetes, 7 recommended simultaneous screening for cardiovascular disease. Almost all guidelines suggested simultaneous pancreas–kidney transplantation for patients with type 1 diabetes but did not recommend age thresholds.</td>
</tr>
<tr>
<td>Machado et al. [242] 2012</td>
<td>Kidney and Pancreas Transplantation in the United States, 1998–2007 (n = 40 825 to 76 070) from the national Organ Procurement and Transplantation Network (OPTN) kidney or simultaneous pancreas–kidney (SPK) transplant.</td>
<td>Diabetes was not contraindicated unless associated with multiple organ failure or significant cardiovascular complications. Of the 10 guidelines discussing diabetes, 7 recommended simultaneous screening for cardiovascular disease. Almost all guidelines suggested simultaneous pancreas–kidney transplantation for patients with type 1 diabetes but did not recommend age thresholds.</td>
</tr>
<tr>
<td>McCullough et al. [243] 2009</td>
<td>Kidney and Pancreas Transplantation in the United States, 1998–2007 (n = 40 825 to 76 070) from the national Organ Procurement and Transplantation Network (OPTN) kidney or simultaneous pancreas–kidney (SPK) transplant.</td>
<td>Diabetes was not contraindicated unless associated with multiple organ failure or significant cardiovascular complications. Of the 10 guidelines discussing diabetes, 7 recommended simultaneous screening for cardiovascular disease. Almost all guidelines suggested simultaneous pancreas–kidney transplantation for patients with type 1 diabetes but did not recommend age thresholds.</td>
</tr>
<tr>
<td>Patibandla et al. [244] 2012</td>
<td>Kidney and Pancreas Transplantation in the United States, 1998–2007 (n = 40 825 to 76 070) from the national Organ Procurement and Transplantation Network (OPTN) kidney or simultaneous pancreas–kidney (SPK) transplant.</td>
<td>Diabetes was not contraindicated unless associated with multiple organ failure or significant cardiovascular complications. Of the 10 guidelines discussing diabetes, 7 recommended simultaneous screening for cardiovascular disease. Almost all guidelines suggested simultaneous pancreas–kidney transplantation for patients with type 1 diabetes but did not recommend age thresholds.</td>
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<tr>
<td>Patzer et al. [245]</td>
<td>Cohort study using data for incident, adult ESRD patients (1998 to 2002) from the ESRD Network (Georgia, North Carolina, and South Carolina) plus the United Network for Organ Sharing (UNOS) transplant registry through 2005 and the 2000 U.S. Census geographic data. 35,346 subjects, 12% were waitlisted, 45% had diabetes as the primary aetiology of ESRD.</td>
<td>Diabetes was associated with HR of waitlisting of 0.78 (0.72 to 0.85) P &lt;0.0001.</td>
</tr>
<tr>
<td>Ravanan et al. [246]</td>
<td>16,202 incident renal replacement treatment patients (1757 patients with diabetes) from 65 renal centres submitting data to the UK Renal Registry between 1 January 2003 and 31 December 2005, followed until 31 December 2008.</td>
<td>Diabetes was associated with a lower probability of activation on waiting list within two years of start of renal replacement treatment; OR 0.40 (0.36 to 0.45) &lt;0.001.</td>
</tr>
<tr>
<td>Segev et al. [247]</td>
<td>Prospective cohort of 132,353 patients who were registered for kidney transplantation in the United States between 1995 and 2006.</td>
<td>In a fully adjusted model, diabetes was significantly associated with a lower probability of being bypassed for a kidney offer (IRR 0.94; 95% CI 0.90–0.98).</td>
</tr>
<tr>
<td>Oniscu et al. [248]</td>
<td>4523 adults (226 patients with diabetes) starting renal replacement therapy in Scotland between 1 January 1989 and 31 December 1999.</td>
<td>Patients were less likely to be placed on the list if they had diabetes; RR 0.81 (0.64 to 1.01) P = 0.06.</td>
</tr>
<tr>
<td>Satayathum et al. [249]</td>
<td>5267 randomly selected DOPPS I patients (35.9% patients with diabetes) in dialysis units in the United States, Europe, and Japan who received chronic HD therapy for at least 90 days in 2000.</td>
<td>Patients with diabetes had a non-significantly lower relative rate of transplantation; RR 0.93 (P = 0.52).</td>
</tr>
</tbody>
</table>
Chapter 1.4. B. What is the benefit of renal transplantation for dialysis patients with diabetes and CKD stage 5?

<table>
<thead>
<tr>
<th>Study</th>
<th>-Publication Year -Time Frame -Location</th>
<th>Design</th>
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<th>Quality of evidence</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Abbott et al.</td>
<td>2001 -2001 North America</td>
<td>Retrospective cohort study</td>
<td>Patients with ESRD due to diabetes having their first dialysis in or after 1992 being placed on the waiting list 1 July 1994–30 June 1997</td>
<td>No diabetes as cause of ESRD waitlisting before 1992.</td>
<td>Age 57.4 ± 11.3 -Gender: 59% male</td>
<td>Transplantation (n = 5683)</td>
<td>Remaining on the waiting list (n = 5686) -1.93 years</td>
<td>1.93 years</td>
<td>Congestive heart failure</td>
<td>HR 0.64 (0.54–0.77; P &lt;0.05) Representative Dea ness uncertain Registry-based reporting of outcome</td>
<td>High chance of type 1 error</td>
<td>Adjustment for covariates renders the association non-significant</td>
</tr>
<tr>
<td>Abbott et al.</td>
<td>2002 -2002 North America</td>
<td>Retrospective cohort study</td>
<td>Patients with ESRD due to diabetes having their first dialysis in or after 1992 being placed on the waiting list 1 July 1994–30 June 1997</td>
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<td>Age 57.4 ± 11.3 -Gender: 59% male</td>
<td>Transplantation (n = 5683)</td>
<td>Remaining on the waiting list (n = 5686) -1.93 years</td>
<td>1.93 years</td>
<td>Sepsis due to Gram-negative organisms -Bacterial septicaemia -Sepsis due to urinary tract infection</td>
<td>HR 3.32 (2.61–4.23; P &lt;0.05) -HR 1.20 (1.02–1.55; P &lt;0.05) -HR 10.43 (6.72–16.17)</td>
<td>Generalizability uncertain Registry-based reporting of outcome Incomplete adjustment for covariates Possible selection bias</td>
<td>Selection bias: patients remaining waitlisted are possibly more highly immunized with intrinsically a higher infection risk post-transplantation, which could alter the observed outcome in accordance with longer follow-up time No data on prophylaxis, induction, immunosuppressive regimen, bladder catheterization</td>
</tr>
<tr>
<td>Adang et al.</td>
<td>1996 -1996 Europe</td>
<td>Prospective case-control study</td>
<td>All patients receiving SPK from June 1992-January 1994</td>
<td>-Transplantation (n = 17) -SPK with early loss of pancreas after transplantation and preservation of kidney function (n = 5)</td>
<td>-QoL.</td>
<td>-Visual analogue score, disease-specific questionnaire. NHP-1; NPHS-2 ABS, family. Impact questionnaire all better in the intervention group</td>
<td>Very small patient numbers Possible selection bias. No comparator group of type 1 patients with diabetes remaining on the waiting list No adjustment for covariates</td>
<td>Generalizability uncertain Selection bias Centre bias No adjustment for covariates</td>
<td>Mash-up of numerous comparisons, differences both adjusted and unadjusted with alternating comparators, differences in time points and very few long-term assessments High risk for type 1 error</td>
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<tr>
<td>Allen et al.</td>
<td>1997 -1997 Australia/New Zealand</td>
<td>Before-after study</td>
<td>Patients with insulin-dependent diabetes mellitus and ESRD receiving SPK without graft loss before 6 months posttransplantation in which pre- and post-transplantation conduction velocity was available. In addition, a group of SPK recipients with early pancreatic loss from graft thrombosis who maintained a functioning kidney allograft as well as one type I diabetic recipient who was on the SPK waiting list and elected to receive a cadaveric kidney transplant alone before being offered an SPK were also studied.</td>
<td>-Age 38.5 ± 7.9 -Gender: 49% male -Dialysis vintage: 25.2 ± 7.6</td>
<td>-SPK with functioning pancreas graft &gt;6 months (n = 44) -SPK with non-functioning pancreas graft (n = 9)</td>
<td>-Recovery of total NCS after SPK -Recovery of conduction velocity -Recovery of nerve amplitude</td>
<td>-Increased conduction velocity score of 22.2% at 6 months. Improvement in all parameters considered in functioning SPK</td>
<td>Generalizability uncertain Selection bias Centre bias No adjustment for covariates</td>
<td>Mash-up of numerous comparisons, differences both adjusted and unadjusted with alternating comparators, differences in time points and very few long-term assessments High risk for type 1 error</td>
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### Chapter 1.A.B. Continued

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<th>-Exclusion criteria</th>
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<th>-Intervention (n)</th>
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<tr>
<td><strong>Fiorina et al. [85]</strong></td>
<td>-2005</td>
<td>-Europe</td>
<td>Before-after study</td>
<td>-Type 1 diabetes patients with a functional kidney graft received from a cadaveric donor.</td>
<td>-Age: 48.6 years</td>
<td>-Renal transplantation followed by islet transplantation (n = 17).</td>
<td>-Lower need of insulin in the kidney-islet group</td>
<td>Cardiovascular parameters improved in the kidney-islet group, but not in the kidney-only group</td>
<td>High potential for selection bias. Small patient numbers No adjustment for confounders No valid outcome measures (surrogates for clinical relevant endpoints). Multi-comparisons without appropriate statistical approach and with high risk of type 1 error due to cherry picking</td>
<td>Comparison of cardiovascular outcome in two groups while the exclusion criterion to be allocated to the intervention group (=islet) is partially cardiovascular</td>
</tr>
<tr>
<td><strong>Gabier et al. [86]</strong></td>
<td>-1995</td>
<td>-North America</td>
<td>Before-after study</td>
<td>-Type 1 diabetes patients transplanted with a single kidney, with pancreas-kidney or pancreas transplantation after kidney transplantation</td>
<td>-Age: 45 years</td>
<td>-Renal transplantation follow-up of kidney transplant (11).</td>
<td>-Cardiovascular status: echocardiographic measures</td>
<td>Sustained improvement of echocardiographic measures in pancreas versus kidney alone group</td>
<td>High potential for selection bias. Small patient numbers No adjustment for confounders</td>
<td>Multi-comparison with risk of type 1 error. No baseline characteristics</td>
</tr>
<tr>
<td><strong>Giannarelli et al. [84]</strong></td>
<td>-2005</td>
<td>-Europe</td>
<td>Before-after study</td>
<td>-SPK patients with retinopathy</td>
<td>-Age: 40 ± 7 years</td>
<td>-Renal transplantation not followed by islet transplantation (n = 25).</td>
<td>-Lower need of insulin in the kidney-islet group</td>
<td>Glycaemic control Cardiovascular status (change in surrogate markers of cardiac function: ejection fraction, IMT, QT dispersion, NaK-ATPase activity, BNP and ANP)</td>
<td>High potential for selection bias. Small patient numbers No adjustment for confounders No valid outcome measures (surrogates for clinical relevant endpoints). Multi-comparisons without appropriate statistical approach and with high risk of type 1 error due to cherry picking</td>
<td>Comparison of cardiovascular outcome in two groups while the exclusion criterion to be allocated to the intervention group (=islet) is partially cardiovascular</td>
</tr>
<tr>
<td><strong>Kleinclauss et al. [63]</strong></td>
<td>-2009</td>
<td>-North America</td>
<td>Retrospective cohort study</td>
<td>-Diabetic recipients of living donor (LD) kidney transplants</td>
<td>-Age: 45 years</td>
<td>-Progression to end-stage kidney disease (diagnosis only).</td>
<td>-Year graft survival 85.2% (SPK) versus 70% kidney transplant alone (P = 0.01)</td>
<td>Generalizability uncertain (very high HbA1c). Potential for selection bias (for instance more smokers in the waitlisted group) Univariate differences Small patient numbers Follow-up incomplete</td>
<td>High potential for selection bias. Small patient numbers No adjustment for confounders No mentioning the assessment after graft loss in the SPK group</td>
<td>Single-centre data. No data exist on baseline characteristics of comparator non-transplanted type 1 diabetes patients. Comparator group ill-defined with potential of selection bias. No mentioning the assessment after graft loss in the SPK group. Generalizability uncertain (very high HbA1c). Potential for selection bias (for instance more smokers in the waitlisted group) Univariate differences Small patient numbers Follow-up incomplete</td>
</tr>
<tr>
<td><strong>La Rocca et al. [64]</strong></td>
<td>-2001</td>
<td>-Europe</td>
<td>Retrospective cohort study</td>
<td>-Type 1 diabetic ESKD patients</td>
<td>-Age: 45.6 years</td>
<td>-Progression to end-stage kidney disease (diagnosis only).</td>
<td>-Year graft survival 85.2% (SPK) versus 70% kidney transplant alone (P = 0.01)</td>
<td>Generalizability uncertain (very high HbA1c). Potential for selection bias (for instance more smokers in the waitlisted group) Univariate differences Small patient numbers Follow-up incomplete</td>
<td>High potential for selection bias. Small patient numbers No adjustment for confounders No mentioning the assessment after graft loss in the SPK group. Generalizability uncertain (very high HbA1c). Potential for selection bias (for instance more smokers in the waitlisted group) Univariate differences Small patient numbers Follow-up incomplete</td>
<td>Single-centre data. No data exist on baseline comorbidity (CV disease). CV mortality is higher in the KTA-E group. Also, KTA-E patients have more frequently type 2 diabetes as cause of ESRD possibly with issues of obesity. No adjustment for comorbid status in the Cox model. Patients remaining on the waiting list for immunological reasons such as low HLA matching and/or antibodies. This might confer a higher comorbid state.</td>
</tr>
<tr>
<td>Sureshkumar et al. [252]</td>
<td>2006-1988–1996 -North America</td>
<td>Retrospective case-control study</td>
<td>Type I diabetes patients with ESKD minimum follow-up of 3 months after transplantation</td>
<td>Age 44 years</td>
<td>Male gender: 59%</td>
<td>SPK (n = 43)</td>
<td>Type I diabetes patients with ESKD waitlisted for transplantation (n = 23)</td>
<td>QoL: Diabetes QoL (DQoL), Short Form-36 (SF-36) and Quality of Well-Being (QWB) questionnaires were utilized (overall 15 compounds were being tested)</td>
<td>S-PK group had better satisfaction subscore compared with WL (1.8 ± 0.5 versus 2.6 ± 0.6, P &lt;0.001) and better impact subscore compared with WL (1.7 ± 0.6 versus 2.3 ± 0.6, P &lt;0.01) groups. There were no significant differences on physical/mental composite scores of SF-36. QWB score was better in SPK group versus WL group (0.62 ± 0.11 versus 0.55 ± 0.04, P &lt;0.05). Potential for selection bias/allocation bias Informative censoring in the follow-up Univariate differences Multi-comparison; high chance of type 1 error Small patient numbers Longitudinal outcome data (QoL) available only in a subset of patients with CKT/SPK Some patients in the kidney transplantation groups were offered SPK Transplantation but opted for kidney-alone transplantation (either cadaver or living). So differences in QoL in groups might reveal disparities in personality traits</td>
<td></td>
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<tr>
<td>Young et al. [78]</td>
<td>2009-2000–2007 -North America</td>
<td>Retrospective cohort study</td>
<td>Adult (age 20 to 59) type I patients with diabetes who received a solitary first-time kidney transplant -Dual organ transplants other than SPKTs</td>
<td>Age 41.9 years</td>
<td>Male gender: 59%</td>
<td>Living donation kidney (n = 3309)</td>
<td>Progression to end-stage kidney disease -Survival (mortality)</td>
<td>-7-year graft loss: HR 0.71 (0.61–0.83; P &lt;0.001). -7-year survival: HR 0.78 (0.65–0.94; P = 0.007)</td>
<td>Large sample size Adjustment for main demographics, somatometrics and biological data Possible selection bias In the cadaveric graft population; more blacks and longer dialysis vintage Maybe also lower socio-economic status (not controlled for) which affects outcome, partially through dyscompliance, drug fatigue The healthiest patients are allocated to SPK and receive the highest quality organs -Centre bias: SPK especially in the early era mostly in high-volume centres No confidence intervals provided</td>
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<tr>
<td>Reddy et al. [77]</td>
<td>2003-1987–1996 -North America</td>
<td>Retrospective cohort study</td>
<td>Type I diabetes who received a kidney transplant between 1987 and 1996 -Patients who received segmental pancreas grafts from living donors</td>
<td>Age 40.7 years</td>
<td>Male gender: 59%</td>
<td>SPK (n = 4602) -LDK (n = 3991) -Cadaveric kidney only (n = 9956)</td>
<td>Survival/mortality</td>
<td>-Survival at 5y with survivors with renal allograft function at 1 year: respectively 89.8, 87.8 and 79.7% -Mortality beyond 18 months posttransplantation in SPK versus LDK transplantation: HR 0.86; P = 0.02 -Survival 5 years after transplantation: 81%, 84% and 71% respectively; SPK versus LDK transplantation HR 0.92; P = 0.04 -Mortality 18 months post-transplantation in SPK versus LDK: HR 2.2; P &lt;0.001 -HR 0.8 (0.49–1.31; P = 0.38) -78.2% SPK versus 65.5% kidney transplantation alone -96.4% SPK versus 95.2% kidney transplantation alone -HR 0.77 (0.4–1.48; P = 0.43) -89.6% SPK versus 78.2% kidney transplantation alone High potential for selection bias Centre bias: SPK especially in the early era mostly in high-volume centres No confidence intervals provided</td>
<td></td>
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<tr>
<td>Waki et al. [90]</td>
<td>2006-1995–2002 -North America</td>
<td>Retrospective cohort study</td>
<td>Eligible patients were those who received their first SPK or kidney alone from January 1995 to December 2002 -Survival &lt;1 year post-transplantation</td>
<td>Age 44.4 years</td>
<td>Male gender: 59%</td>
<td>BMI: 25.8 kg/m² -Duration of dialysis: 2.3 years</td>
<td>SPK (n = 544) -Kidney transplantation alone (n = 544)</td>
<td>Progression to end-stage kidney disease (up to December 2004) -Survival free from graft loss (5y) -Survival (at one year); -Mortality (up to December 2004) -Survival (at five year)</td>
<td>-HR 0.8 (0.49–1.31; P = 0.38) -78.2% SPK versus 65.5% kidney transplantation alone -96.4% SPK versus 95.2% kidney transplantation alone -HR 0.77 (0.4–1.48; P = 0.43) -89.6% SPK versus 78.2% kidney transplantation alone High potential for selection bias Incomplete adjustment. Registry data UNOS; generalizability uncertain</td>
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</tbody>
</table>

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<th>Quality of evidence</th>
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<tr>
<td>Ziaja et al. [89]</td>
<td>-2009</td>
<td>Prospective cohort study</td>
<td>-Type 1 diabetes receiving kidney transplantation alone with or without failure of the pancreas graft after transplantation and/or receiving SPK</td>
<td>-Age 37 years -SPK (n = 21) -Patients with only a functional kidney graft period; those referred to KTA only, or refusing pancreas transplantation or in whom pancreas grafting was technically impossible (n = 17)</td>
<td>-QoL.</td>
<td></td>
<td></td>
<td>-Benefit in SPK group for physical functioning (P = 0.03). -Overall health (P = 0.001). -Pain (P = 0.005). -Effects of kidney disease (P = 0.001) -Symptoms/problem list (P = 0.04). -Cognitive function (P = 0.03)</td>
<td>High potential of selection bias Small patient sample</td>
<td>Generalizability uncertain</td>
<td>No adjustment</td>
</tr>
<tr>
<td>Wolfe et al. [70]</td>
<td>-1999 -1997–1996</td>
<td>Retrospective cohort study</td>
<td>-Patients under the age of 70 years starting with treatment for end-stage renal disease. -Patients &gt;70 years. Non-reporting of the cause of end-stage renal disease or the region they were from.</td>
<td>-Transplantation of patients with diabetes as cause of ESRD (n = 7262) -Patients with diabetes as cause of ESRD remaining on the waiting list (n = 7926)</td>
<td>-Survival was analysed as the time from initial placement on the waiting list to death, with data censored at the time of receipt of a first transplant from a living donor or on 31 December 1997 (patients with diabetes as cause of ESRD)</td>
<td>-RR 0.27 (0.24–0.30; P &lt; 0.001)</td>
<td></td>
<td></td>
<td>Incomplete adjustment Registry data</td>
<td>Misclassification bias excluding diabetic patients on the waiting list</td>
<td>No separation type 1/type 2 diabetes</td>
</tr>
<tr>
<td>Weiss et al. [81]</td>
<td>-2009 -1997–2005</td>
<td>Retrospective cohort study</td>
<td>-All patients on the SPK waiting list who were transplanted January 1997 through December 2005. -Exclusion criteria included death or kidney graft loss before 12 months post-transplant or follow-up less than 12 months at the time of analysis</td>
<td>-Age 39.9 years -Male gender: 59% -SPK with functional pancreas at year 1 (n = 6486) -SPK with pancreas loss the first year (n = 371) -LKD (n = 904) -DDK (n = 520)</td>
<td>-Progression to end-stage kidney disease during follow-up (DDK versus SPK with functional pancreas). -Progression to end-stage kidney disease; survival free from renal graft loss 84 months after transplantation (SPK with functioning pancreas at 1 year as reference). -Survival free from graft loss DDK versus LDK.</td>
<td>-HR 1.63 (1.28–2.06; P &lt; 0.001) -72% SPK, 59.8% SPK with pancreas loss, 62.6% LDK and 497% DDK -94.8% DDK versus 90.3% DDK. -HR 1.51 (1.22–1.88; P &lt; 0.001) -HR 1.64 (1.31–2.05; P &lt; 0.001) -92% SPK versus 94.8% LDK (P = 0.001) -HR 1.98 (1.47–2.67; P &lt; 0.001) -95.6% (DDK) versus 97.2% (LKD) (P = 0.01) -95.9% (SPK) versus 97.2% (LKD) (P = 0.04) -HR 2.66 (1.98–3.57; P &lt; 0.001) -88.6% SPK with functioning graft versus 73.9% SPK with pancreas graft loss versus</td>
<td>High probability of selection bias</td>
<td>Generalizability uncertain</td>
<td>Registry data (SRTR)</td>
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</table>
Continued to SPK with functioning pancreas one year after transplantation as reference. Survival the first year in DDK versus LDK.

-80.0% LDK versus 64.8% DDK (HR 2.05 (1.48–2.83; P < 0.001))


- The study population consisted of patients with ESRD due to type 1 DM who were 18 years or older at the time of the onset of ESRD and were enrolled on the transplant waiting list between 1 October 1988 and 30 June 1997.

- Missing date of wait-list registration receiving living donation or never waitlisted.

- Transplants reported to the CTS from 1984 to 2000 were analysed. All patients who were reported to the study centre with type 1 diabetes and ESRD and received either a first SPK transplant from a deceased donor or a kidney transplant alone, from either a deceased donor (DDK) or a living donor (LDK), were included. Transplanted between 1991–2000.

- Patients with pancreas after kidney transplantation.

- Recipients who were older than 45 yr at the time of transplantation.

- Age 35.4 years -Male gender: 55%

- Age 35.7 years -Male gender: 58%

-SPK (n = 4718)

- LDK (n = 671)

- DDK (n = 4127)

-SPK (n = 3525)

- LDK (n = 2190)

- DDK (n = 5705)

- Progression to end-stage kidney disease 6–10 years after transplantation (death censored) SPK versus DDK.

- Progression to end-stage kidney disease (death censored) from year 2 to 5 post-transplantation patients transplanted between 1991–2000 SPK versus DDK.

- Progression to end-stage kidney disease 6–10 years after transplantation (death censored) SPK versus LDK.

- Progression to end-stage kidney disease (death censored) from year 2 to 5 post-transplantation patients.

-HR 0.75 (0.63–0.89; P < 0.05)

- HR 0.96 (0.79–1.17; P = 0.711)

- HR 1.31 (0.94–1.83; P = 0.111)

- HR 1.32 (1.74–1.7; P = 0.052)

- HR 0.89 (0.63–1.27; P = 0.533)

- HR 0.52 (0.37–0.73; P < 0.001)

- HR 0.64 (0.51–0.82; P < 0.001)

- HR 1.31 (0.96–1.79)

- HR 0.82 (0.66–1.01)

- HR 0.55 (0.36–0.83; P = 0.005)

- HR 1 (0.79–1.26; P = 0.931)

- HR 0.96 (0.79–1.17; P = 0.711)

- HR 1.31 (0.94–1.83; P = 0.111)

Generalizability uncertain

Potential for selection bias

Incomplete adjustment

Potential for selection bias

Incomplete adjustment

Potential for selection bias (only patients who were likely to have developed DM before the age of 24 years were included in the non-SPK study groups).

Morath et al. [80] -2008 -1984–2000 -Europe

Retrospective cohort study

-Transplants reported to the CTS from 1984 to 2000 were analysed. All patients who were reported to the study centre with type 1 diabetes and ESRD and received either a first SPK transplant from a deceased donor or a kidney transplant alone, from either a deceased donor (DDK) or a living donor (LDK), were included. Transplanted between 1991-2000.

- Patients with pancreas after kidney transplantation.

- Recipients who were older than 45 yr at the time of transplantation.

- Age 35.7 years -Male gender: 58%

-SPK (n = 3525)

- LDK (n = 2190)

- DDK (n = 5705)

- Progression to end-stage kidney disease 6–10 years after transplantation (death censored) SPK versus DDK.

- Progression to end-stage kidney disease (death censored) from year 2 to 5 post-transplantation patients transplanted between 1991–2000 SPK versus DDK.

- Progression to end-stage kidney disease 6–10 years after transplantation (death censored) SPK versus LDK.

- Progression to end-stage kidney disease (death censored) from year 2 to 5 post-transplantation patients.

- HR 1 (0.79–1.26; P = 0.931)

- HR 0.96 (0.79–1.17; P = 0.711)

- HR 1.31 (0.94–1.83; P = 0.111)

- HR 1.32 (1.74–1.7; P = 0.052)

- HR 0.89 (0.63–1.27; P = 0.533)

- HR 0.52 (0.37–0.73; P < 0.001)

- HR 0.64 (0.51–0.82; P < 0.001)

- HR 1.31 (0.96–1.79)

- HR 0.82 (0.66–1.01)

- HR 0.55 (0.36–0.83; P = 0.005)

- HR 1 (0.79–1.26; P = 0.931)

- HR 0.96 (0.79–1.17; P = 0.711)

- HR 1.31 (0.94–1.83; P = 0.111)

- HR 1.32 (1.74–1.7; P = 0.052)

- HR 0.89 (0.63–1.27; P = 0.533)

- HR 0.52 (0.37–0.73; P < 0.001)

- HR 0.64 (0.51–0.82; P < 0.001)

- HR 1.31 (0.96–1.79)

- HR 0.82 (0.66–1.01)

- HR 0.55 (0.36–0.83; P = 0.005)

- HR = 0.55 (0.36–0.83; P = 0.005)
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<tr>
<td>Poommipanit et al. [75]</td>
<td>2010</td>
<td>2000–2008</td>
<td>North America</td>
<td>Retrospective cohort study</td>
<td>Patients with type 1 diabetes according to diagnosis codes, aged 18 to 59 years, who were waitlisted for kidney-pancreas transplantation between January 2000 and December 2007 with follow-up data available through August 2008</td>
<td>-Dual organ transplants other than kidney-pancreas transplants</td>
<td>-Age 28.2 years Male gender: 59%</td>
<td>-PALK (n = 807)</td>
<td>-SPK (n = 5580)</td>
<td></td>
<td>-Progression to end-stage kidney disease, graft failure of the kidney in PALK versus SPK</td>
<td>-HR 0.48 (0.39–0.60; P &lt; 0.01) -77% SPK versus 86% PALK -HR 0.52 (0.39–0.70; P &lt; 0.01) -99.24% PALK versus 95.55% SPK</td>
<td>High potential for selection bias</td>
<td>Less comorbidity in the SPK group with incomplete correction for comorbid status</td>
</tr>
<tr>
<td>Gross et al. [253]</td>
<td>1992</td>
<td>1980–1991</td>
<td>North America</td>
<td>Prospective case-control study</td>
<td>-Functioning pancreas graft more than one year post-transplantation. Pancreas graft not for type 1 diabetes and both pancreas and kidney graft failure (n = 2).</td>
<td></td>
<td>-Age 36.8 years Male gender: 35%</td>
<td>-Successful pancreas Transplant (n = 65)</td>
<td>-Failed pancreas Transplant (n = 64)</td>
<td></td>
<td>-Positive health perceptions Pain Ability to function socially Ability to perform routine activities (Karnofsky)</td>
<td>-51.9 successful versus 28.9 failed pancreas -33.9 successful transplant versus 45.3 failed transplant -84.9 successful transplant versus 71.3 failed transplant -2.92 successful versus 3.63 failed transplant</td>
<td>Small patient numbers Generalizability uncertain High potential for selection bias</td>
<td>Possibly outdated study</td>
</tr>
<tr>
<td>Zehrer et al. [254]</td>
<td>1993</td>
<td>1990–1990</td>
<td>North America</td>
<td>Retrospective case-control study</td>
<td>-Functioning pancreas transplant for type 1 diabetes mellitus at least one year post-transplantation in August 1990. Non-diabetic pancreas transplants</td>
<td></td>
<td>-Age 36.5 years Male gender: 32%</td>
<td>-Functioning pancreas (n = 62)</td>
<td>-Non-functioning pancreas (n = 67)</td>
<td></td>
<td>-Overall life satisfaction DQoL Diabetes Management Subscale Health satisfaction Karnofsky index score DQoL Satisfaction Measure</td>
<td>-P &lt; 0.01 versus control group on all measures</td>
<td>High potential for selection bias</td>
<td>Possibly outdated study Significant heterogeneity study population</td>
</tr>
<tr>
<td>Study</td>
<td>Year Range</td>
<td>Region</td>
<td>Study Design</td>
<td>Description</td>
<td>Demographics</td>
<td>Outcomes</td>
<td>Potential Problems</td>
<td></td>
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<tr>
<td>Becker et al. [67]</td>
<td>1966-1995</td>
<td>North America</td>
<td>Retrospective Cohort study</td>
<td>Type 1 diabetic patients who developed ESRD between the ages of 21 and 40 and received an initial kidney or SPK transplantation</td>
<td>80% Caucasian, 59.5% Male</td>
<td>0.5 observed/expected life span</td>
<td>High potential for selection bias, incomplete adjustment, possibly outdated study, very high rejection rates, possibly affecting the overall generalizability</td>
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<tr>
<td>Lindahl et al. [68]</td>
<td>1983-2010</td>
<td>Europe</td>
<td>Retrospective cohort study</td>
<td>Diabetic ESRD who received a first kidney or a combined transplant (SPK)</td>
<td>Age: 47 years, Male gender: 70.1%</td>
<td>Renal graft loss</td>
<td>Possible selection bias, adjustment for main demographics, somatometrics and biological data</td>
<td></td>
<td></td>
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<tr>
<td>Mohan et al. [69]</td>
<td>1992-2002</td>
<td>Europe</td>
<td>Retrospective cohort study</td>
<td>Patients with type 1 diabetes undergoing kidney alone or SPK transplantation; No SPK in patients &gt;50 years old</td>
<td>Age 47 years old, Male gender: 60%</td>
<td>Renal graft survival</td>
<td>High potential of selection bias, generalizability uncertain</td>
<td></td>
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<tr>
<td>Sorensen et al. [73]</td>
<td>1990-2005</td>
<td>Europe</td>
<td>Retrospective cohort study</td>
<td>Patients on the waiting list or receiving kidney transplant Data pooled from the Danish National Register on Dialysis and Transplantation and from the Scandiatransplant database</td>
<td>Age 42.6 (diabetes patients) 46.6±13.8 years (non-diabetes patients), 9% with type 1 diabetes, 9% with type 2 diabetes</td>
<td>Renal graft survival</td>
<td>Possible selection bias, generalizability uncertain, results adjusted for the most important confounders, not adjusted for additional confounders</td>
<td></td>
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<tr>
<td>Keddis et al. [71]</td>
<td>1996-2007</td>
<td>North America</td>
<td>Retrospective cohort study</td>
<td>Patients receiving a kidney transplantation between 1996 and October 2007, Patients with non-renal transplants</td>
<td>Age 52.3 ± 13.8 years, Male gender: 58%</td>
<td>Five-year mortality, five-year mortality in recipients transplanted after 2004 (2005-2007)</td>
<td>Patients with diabetes were more likely to have undergone coronary intervention pre-transplantation</td>
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</tbody>
</table>

Continued
Caucasian: 92%  
- Pre-transplant cardiovascular events: 26%  
- Living donation: 76%  

Kidney transplantation \((n = 1275)\):
- CV death during follow-up  
- CV death during 2003-2007 \((2.155 – 6.618; P < 0.0001)\)  
- \(HR = 2.265 (0.978 – 5.241; P = 0.056)\)

Uncertain potential for selection bias

No clear discrimination between type 1 and type 2 diabetes

Chapter 1.4.B. Continued

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Patient characteristics</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Cosio et al. [72]              | Retrospective cohort study | Patients receiving a first kidney transplant from January 1998 to June 2006  
Recipient of pancreas or other transplants  
- Age: 53 ± 14.4 years  
- Male gender: 57%  
- Obese: 32%  
- Race: Caucasian: 92%  
- Pre-transplant cardiovascular events: 23%  
- Patients with diabetes receiving a kidney transplantation \((n = 212)\)  
- Patients without diabetes receiving a kidney transplantation \((n = 721)\)  
- Pre-transplant cardiovascular events: 26%  
- Living donation: 76%  | - Death-censored graft survival during follow-up  
- Post-transplant cardiovascular events  
- Cardiovascular mortality  
- All-cause mortality  
- Pre-transplant cardiovascular events: 23%  
- Living donation: 76%  | -HR 1.19 (0.76–1.86; P = 0.442)  
- 53 (7.4%) in subjects without diabetes versus 53 (25%) in subjects with diabetes \(P < 0.001\)  
- 8 (1.1%) in subjects without diabetes versus 25 (12%) in subjects with diabetes \(P < 0.001\)  
- 44 (6.1%) in subjects without diabetes versus 53 (25%) in subjects with diabetes \(P < 0.001\)  | Single-centre data  
Small patient numbers (especially in subgroups)  
Generalizability uncertain  
Potential for selection bias  | Univariate comparison | Patients with diabetes were significantly older and heavier  
No clear discrimination between type 1 and type 2 diabetes |

| Rayhill et al. [66]            | Retrospective cohort study | Patients with diabetes receiving a kidney transplantation between 1986 and 1996  
- Age: 39 years  
- Duration IDDM 23 years  
- SPK \((n = 379)\)  
- LDK \((n = 130)\)  
- DKD \((n = 296)\)  | - One-year renal allograft survival  
- Five-year renal allograft survival  
- One-year patient survival  
- Five-year patient survival  | - In HLA identical LDK, haplo-identical LDK, SPK and DKD respectively 96, 94, 97 and 86%.  
- In HLA identical LDK, haplo-identical LDK, SPK and DKD respectively 85, 72, 78 and 64%.  
- In HLA identical LDK, haplo-identical LDK, SPK and DKD respectively 100, 99, 96 and 94%.  
- In HLA identical LDK, haplo-identical LDK, SPK and DKD respectively 94, 85, 88 and 72%  | Generalizability uncertain  
Univariate comparison  
(multivariate analysis only in the overall cohort)  
No exclusion criteria | Rejection rate the first year of up to 77% in SPK group (48% in the DKD group)  
Similar demographic composition of LDK and SPK groups  
Unknown prevalence of type 1 and type 2 diabetes |

| Norman et al. [82]             | Retrospective cohort study | All primary SPK transplants performed in the United States between 1 January 2000, and 31 December 2007, who had maintained kidney graft function at 90 days post-transplantation and follow-up up to Feb 1th 2010  
- Age <18 years and kidney graft loss the first 90 days  
- Age 41.4 ± 8.2 years  
- Male gender: 61.7%  
- Mean duration of diabetes: 26.6 ± 8.1 years  
- SPK without pancreas graft the first 90 days \((n = 5812)\)  
- SPK with pancreas graft loss the first 90 days \((n = 470)\)  | - Kidney graft failure in those with versus without pancreas graft loss  
- Graft survival with versus without pancreas graft loss at 3 year  
- Graft survival with versus without pancreas graft loss at 5 year  
- Patient survival with versus without pancreas graft loss at 3 year  
- Patient survival with versus without pancreas graft loss at 5 year  | -HR 3.78 (1.95–7.35; \(P < 0.001\))  
- 93 versus 94% \((P = 0.266)\)  
- 90 versus 91% \((P = 0.490)\)  
- 90.4 versus 94.8% \((P < 0.001)\)  
- 86.2 versus 92.1% \((P < 0.001)\)  
-HR 2.18 (1.67–2.85; \(P < 0.001)\)  | Generalizability uncertain  
Registry data (SRTR)  
Potential for selection bias  | Incomplete adjustment  
Missing data |
<table>
<thead>
<tr>
<th>Study</th>
<th>Retrospective cohort study</th>
<th>Type 1 diabetes patients receiving a kidney transplantation between 1994 with reporting in UNOS registry</th>
<th>Patients transplanted in centres which offer only one option for type 1 diabetes (SPK or DKT)</th>
<th>-Age: 40.8 years</th>
<th>-Male gender: 58%</th>
<th>-Black race: 12.8%</th>
<th>-SPK (n = 3642)</th>
<th>-DKT (n = 2374)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bunnapradist et al. [225]</td>
<td>2003-1994-1997 North America</td>
<td>Type 1 diabetes patients receiving a kidney transplantation between 1994 with reporting in UNOS registry</td>
<td>Patients transplanted in centres which offer only one option for type 1 diabetes (SPK or DKT)</td>
<td>-SPK</td>
<td>-DKT</td>
<td>-SPK</td>
<td>-DKT</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>-Graft loss DKT versus SPK</td>
<td>-Mortality DKT versus SPK</td>
<td>-HR 0.98 (0.85–1.12; P = 0.73)</td>
<td>-HR 1.06 (0.88–1.28; P = 0.53)</td>
<td></td>
</tr>
</tbody>
</table>

Possible selection bias
No living donation comparator group
Generalizability uncertain
Incomplete adjustment

Patients who received SPK were younger, less often sensitized, transplanted after shorter periods on dialysis, and less often black
Slightly outdated analysis
Chapter 2.3

A. Is any oral drug superior to another in terms of mortality/complications/glycaemic control in diabetic patients with CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²)?

B. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), is maximal oral therapy better than starting/adding insulin in an earlier stage?
# Chapter 2.3. General data on included systematic reviews on different glycaemia-lowering drugs

<table>
<thead>
<tr>
<th>First Author</th>
<th>Publication year</th>
<th>Setting</th>
<th>No of studies overall</th>
<th>Specific for advanced CKD?</th>
<th>AMSTAR score</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Safety and Efficacy of Glimepiride as Treatment for Type 2 Diabetes: A Systematic Review and Meta-Analysis of Randomized Trials | Landman et al. [255] 2014 | Patients: adults with type 2 diabetes  
Medication/intervention: studies comparing glimepiride (either short or long-acting release)  
Comparison: with other glucose-lowering drugs; trials using placebo, diet, insulin or rosiglitazones were excluded. | 19 RCTs | No | 10 | |
| Comparative Effectiveness and Safety of Medications for Type 2 Diabetes: An Update Including New Drugs and 2-Drug Combinations | Bennet et al. [117] 2011 | Patients: T2DM  
Medication/intervention: metformin, second-generation sulfonylureas (SGSUs), TZDs, meglitinides, DPP-4 inhibitors and GLP-1 agonists  
Comparison: as monotherapy and in combination | 140 RCTs and 26 observational | NO | 5 | |
| Predictors of response to dipeptidyl peptidase-4 inhibitors: evidence from randomized clinical trials | Monami et al. [256] 2011 | Patients: T2DM  
Medication/intervention: maximal dose DPP-4 inhibitors, other oral drugs (TZDs, metformin, sulfonylurea, α-glucosidase inhibitors)  
Comparison: DPP-4 inhibitors vs. other oral drugs or insulin or placebo as monotherapy | 44 | NO | 5 | |
| Comparison of different drugs as add-on treatments to metformin in type 2 diabetes: A meta-analysis | Monami et al. [257] 2008 | Patients: T2DM with inadequate glycaemic control on metformin  
Medication/intervention: add-on to metformin: glibenclamide, glyburide, glipizide, gliclazide, chlorpropamide, tolbutamide, glimepiride, gliclame, repaglinide, nateglinide, acarbose, miglitol, pioglitazone, rosiglitazone, troglitazone, exenatide, sitagliptin, vildagliptin, muraglitaz, pramlintide, insulin, glargine, lispro, aspart, glulisine and detemir  
Comparison: metformin plus placebo vs. metformin plus other drugs, or head-to-head comparisons | 16 | NO | 4 | |
| Meglitinide analogues for type 2 diabetes mellitus | Black et al. [258] 2009 | Patients: T2DM  
Medication/intervention: meglitinide analogues, placebo, metformin, insulin  
Comparison: meglitinide analogues to placebo, head-to-head, metformin or in combination with insulin | 15 | NO | 11 | |
Medication/intervention: SU (glimepiride, tolbutamide, glipizide, glibenclamide)  
Comparison: fixed-dose sulfonylurea monotherapy or sulfonylurea added on to other glucose lowering treatments (metformin, insulin or TZDs) | 31 | NO | 6 | |
| Dipeptidyl peptidase-4 (DPP-4) inhibitors for type 2 diabetes mellitus | Richter et al. [118] 2008 | Patients: T2DM  
Medication/intervention: sitagliptin, vildagliptin  
Comparison: sitagliptin or vildagliptin vs. placebo | 25 | NO | 10 | |
<table>
<thead>
<tr>
<th>First Author</th>
<th>Setting</th>
<th>No of studies overall</th>
<th>Specific for advanced CKD?</th>
<th>AMSTAR score</th>
<th>Comments</th>
</tr>
</thead>
</table>
| GLP-1 agonists for type 2 diabetes mellitus | Shyangdan Deepson et al. [260] 2013 | • sitagliptin or vildagliptin vs. single hypoglycaemic agents  
• sitagliptin or vildagliptin in combination with other hypoglycaemic agents vs. other combinations of hypoglycaemic agents  
• sitagliptin or vildagliptin vs. intensive lifestyle interventions | 17 | NO 10 | None of the studies was long enough to assess long-term positive or negative effects. |
| Metformin added to insulin therapy for type 1 diabetes mellitus in adolescents | Abdelghaffar et al. [261] 2009 | Patients: T2DM  
Medication/interventions: GLP-1 agonists (exenatide, liraglutide, lixisenatide, albiglutide)  
Comparisons: placebo, TZDs, DPP-4 inhibitors, insulin glargine, SU, other GLP-1 agonist | 2 | NO 11 | Only side effects of metformin were registered. |
| Metformin monotherapy for type 2 diabetes mellitus Cochrane review | Saenz et al. [262] 2013 | Patients: T2DM on monotherapy  
Medication/intervention: metformin, SU, meglitinide, α-glucosidase inhibitor, insulin  
Comparisons: monotherapy vs. placebo or vs. alternative monotherapy or vs. diet/lifestyle intervention | 29 | NO: renal failure was explicit exclusion criterion | 11 |
| Dipeptidyl peptidase-4 inhibitors for treatment of type 2 diabetes mellitus in the clinical setting: systematic review and meta-analysis | Karagiannis et al. [119] 2012 | Patients: T2DM  
Medications/intervention: DPP-4 inhibitors, metformin, sulfonylurea, pioglitazone, GLP-1 agonists. agonist, basal insulin  
Comparisons:  
• DPP-4 vs. metformin as monotherapy  
• or with a sulfonylurea, pioglitazone, a GLP-1 agonist, or basal insulin combined with metformin | 19 | NO 10 | |
| Comparative safety and effectiveness of metformin in patients with diabetes mellitus and heart failure: systematic review of observational studies involving 34 000 patients | Eurich et al. [263] 2013 | Patients: T2DM with heart failure  
Medication/intervention: Metformin  
Comparison:  
• metformin as monotherapy  
• metformin in combination with other agents  
• other agents without metformin | 9 observational +1 unpublished RCT | YES 8 | |
| Sulphonylurea monotherapy for patients with type 2 diabetes mellitus | Hemmingsen et al. [264] 2013 | Patients: T2DM  
Medication/intervention: first-generation SU (FGSUs): acetohexamide, carbutamide, chlorpropamide, tolbutamide, tolazamide; SGSUs: glibenclamide or glyburide, glibornuride, gliclazide, glipizide; third-generation SUs (TGSUs): gliclazide modified release, glimepiride, glipizide gastrointestinal therapeutic system, lifestyle | 72 | NO 11 | |
<table>
<thead>
<tr>
<th>Study Title</th>
<th>Authors</th>
<th>Year</th>
<th>Patients</th>
<th>Medications/interventions</th>
<th>Comparisons</th>
<th>NO</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison of metformin and insulin vs. insulin alone for type 2 diabetes: systematic review of randomised clinical trials with meta-analyses and trial sequential analyses</td>
<td>Hemmingsen et al. [265]</td>
<td>2012</td>
<td>T2DM</td>
<td>SU monotherapy vs. placebo, no intervention or other glycaemia-lowering interventions</td>
<td>SU monotherapy vs. placebo, no intervention or other glycaemia-lowering interventions</td>
<td>23</td>
<td>obsolete</td>
</tr>
<tr>
<td>Alpha-glucosidase inhibitors for type 2 diabetes mellitus</td>
<td>Van De Laar et al. [266]</td>
<td>2005</td>
<td>T2DM</td>
<td>Metformin, insulin</td>
<td>Metformin, insulin</td>
<td>41</td>
<td>Unclear why study selection was conceived this way; mixed bag of different types of interventions.</td>
</tr>
<tr>
<td>Reappraisal of metformin efficacy in the treatment of type 2 diabetes: A meta-analysis of randomised controlled trials Systematic review: Comparative effectiveness and safety of oral medications for type 2 diabetes mellitus</td>
<td>Boussageon et al. [267]</td>
<td>2012</td>
<td>T2DM</td>
<td>metformin vs. diet alone, vs. placebo, and vs. no treatment; metformin as an add-on therapy; metformin withdrawal</td>
<td>Metformin as an add-on therapy; metformin withdrawal</td>
<td>13</td>
<td>Only benefit for surrogate endpoints; higher risk of hypoglycaemia.</td>
</tr>
<tr>
<td>Comparative efficacy of glimepiride and metformin in monotherapy of type 2 diabetes mellitus: meta-analysis of randomized controlled trials Early combination therapy for the treatment of type 2 diabetes mellitus: systematic review and meta-analysis Sulphonylureas and risk of cardiovascular disease: systematic review and meta-analysis</td>
<td>Zhu et al. [268]</td>
<td>2013</td>
<td>T2DM</td>
<td>Metformin, diet</td>
<td>Metformin vs. glimepiride vs. placebo as monotherapy</td>
<td>15</td>
<td>Also includes observational data, which might induce bias by indication; opposite effect for observational and RCTs; as SU has the same effect as placebo, the apparent negative effect compared to non placebo is probably due to a beneficial effect of metformin. CV mortality and hypoglycaemia not interpretable as very low event rates (24 and 77 respectively).</td>
</tr>
<tr>
<td>Early combination therapy for the treatment of type 2 diabetes mellitus: systematic review and meta-analysis</td>
<td>Phung et al. [269]</td>
<td>2013</td>
<td>T2DM</td>
<td>Metformin, other agents</td>
<td>Metformin monotherapy vs. combination therapy including metformin</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Sulphonylureas and risk of cardiovascular disease: systematic review and meta-analysis</td>
<td>Phung et al. [270]</td>
<td>2013</td>
<td>T2DM</td>
<td>SUs, other agents</td>
<td>all possible combinations, also with placebo</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Efficacy and safety of dipeptidyl peptidase-4 inhibitors and metformin as initial combination therapy and as monotherapy in patients with type 2 diabetes mellitus: a meta-analysis</td>
<td>Wu et al. [271]</td>
<td>2014</td>
<td>T2DM</td>
<td>DPP-4 inhibitors, metformin</td>
<td>DPP-4 inhibitors plus metformin as initial combination therapy or as monotherapy compared to metformin monotherapy</td>
<td>8</td>
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<tr>
<td>Second-line therapy in patients with type 2 diabetes inadequately controlled with metformin monotherapy: a systematic review and mixed-treatment comparison meta-analysis</td>
<td>McIntosh et al. [120]</td>
<td>2011</td>
<td>T2DM</td>
<td>Adults and children with T2DM requiring a second-line antihyperglycaemic agent because of inadequate control (HbA1c &gt; 6.5% (46 mmol/mol), fasting plasma glucose (FPG)&gt; 7 mmol/L or 2-hour postprandial glucose (PPG) &gt; 10 mmol/L)</td>
<td>SU monotherapy vs. placebo, no intervention or other glycaemia-lowering interventions</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>First Author and Publication year</td>
<td>Setting</td>
<td>No of studies overall</td>
<td>Specific for advanced CKD?</td>
<td>AMSTAR score</td>
<td>Comments</td>
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<tr>
<td><strong>Choice of therapy in patients with type 2 diabetes inadequately controlled with metformin and a sulphonylurea: a systematic review and mixed-treatment comparison meta-analysis</strong></td>
<td>McIntosh <em>et al.</em> [124] 2012</td>
<td>metformin monotherapy or because of intolerance to this therap.</td>
<td>33</td>
<td>NO</td>
<td>8</td>
<td>Overall, studies were of poor quality; no mortality data presented.</td>
<td></td>
</tr>
<tr>
<td><strong>Effect of Antihyperglycemic Agents Added to Metformin and a SU on Glycemic Control and Weight Gain in Type 2 Diabetes: A Network Meta-analysis</strong></td>
<td>Gross <em>et al.</em> [125] 2011</td>
<td>Medications/intervention: all available classes of anti-hyperglycaemic therapies</td>
<td>18</td>
<td>NO</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effect of Noninsulin Antidiabetic Drugs Added to Metformin Therapy on Glycemic Control, Weight Gain, and Hypoglycemia in Type 2 Diabetes</strong></td>
<td>Phung <em>et al.</em> [122] 2010</td>
<td>Medications/intervention: non-insulin glycaemia-lowering drugs (TZDs, SUs, glinides, GLP-1 agonists, α-glucosidase inhibitors, and DPP-4 inhibitors), metformin</td>
<td>27</td>
<td>NO</td>
<td>8</td>
<td></td>
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</tr>
<tr>
<td><strong>Cardiovascular Outcomes in Trials of Oral Diabetes Medications</strong></td>
<td>Selvin <em>et al.</em> [273] 2008</td>
<td>Medications/intervention: metformin, SGSUs, and TZDs. Studies including FGSUs or with</td>
<td>40</td>
<td>NO</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study Title</td>
<td>Authors</td>
<td>Methodology</td>
<td>Patients</td>
<td>Medications/interventions</td>
<td>Comparisons</td>
<td>Study Type</td>
<td>No. of Studies</td>
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<tr>
<td>Effect of antidiabetic agents added to metformin on glycaemic control,</td>
<td>Liu et al. [123] 2012</td>
<td>- α-glucosidase inhibitors were excluded.</td>
<td>T2DM who showed inadequate response to metformin monotherapy at randomisation (mean HbA1c ≥ 7.0% [53 mmol/mol]).</td>
<td>SUs, glinides, TZDs, α-glucosidase inhibitors, DPP-4 inhibitors, GLP-1 agonists, basal insulin and biphasic insulin.</td>
<td>Drugs either as monotherapy (vs. placebo or vs. other oral agent) or as dual therapy (all possible combinations).</td>
<td>Network meta-analysis</td>
<td>39</td>
</tr>
<tr>
<td>Hypoglycaemia and weight change in patients with type 2 diabetes: a</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Proportion of patients at HbA1c target &lt;7% with eight classes of antidiabetic drugs in type 2 diabetes: systematic review of 218 randomized controlled trials with 78 945 patients</td>
<td>Esposito et al. [274] 2012</td>
<td></td>
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<td></td>
<td></td>
<td>218</td>
</tr>
<tr>
<td>Efficacy and Safety of Incretin Therapy in Type 2 Diabetes</td>
<td>Amori et al. [113] 2007</td>
<td></td>
<td></td>
<td>Drugs could be either used as monotherapy in drug naive patients, or add-on medication</td>
<td></td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>Efficacy of GLP-1 Receptor Agonists and DPP-4 Inhibitors: Meta-Analysis and Systematic Review</td>
<td>Aroda et al. [275] 2012</td>
<td></td>
<td></td>
<td>Drugs could be either used as monotherapy in drug naive patients, or add-on medication</td>
<td></td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>Glycaemic control and adverse events in patients with type 2 diabetes</td>
<td>Belsey et al. [276] 2008</td>
<td></td>
<td>T2DM inadequately controlled on metformin.</td>
<td>SUs</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>treated with metformin and sulphonylurea: a meta-analysis</td>
<td></td>
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<td></td>
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<td>83</td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>First Author</th>
<th>Publication year</th>
<th>Setting</th>
<th>No of studies overall</th>
<th>Specific for advanced CKD?</th>
<th>AMSTAR score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative Effectiveness of DPP-4 inhibitors in Type 2 Diabetes: A Systematic Review and Mixed Treatment Comparison</td>
<td>Craddy et al. [277] 2014</td>
<td>Patients: T2DM with inadequate glycemic control Medications/interventions: any pharmacological glycaemia-lowering treatment; alogliptin, linagliptin, saxagliptin, sitagliptin, and vildagliptin)</td>
<td>5</td>
<td>NO</td>
<td></td>
<td>Authors sponsored by Takeda to conduct this study.</td>
</tr>
<tr>
<td>GLP-1 agonists as add-on therapy to basal insulin in patients with type 2 diabetes: a systematic review</td>
<td>Berlie et al. [115] 2012</td>
<td>Patients: non-pregnant adults with T2DM Medications/interventions: GLP-1 agonists (exenatide, liraglutide, albiglutide, lixisenatide), basal insulin therapy Comparisons: basal insulin therapy combined with GLP-1 agonists or placebo</td>
<td>8</td>
<td>NO</td>
<td>7</td>
<td>No patient-relevant outcomes assessed. Interpretation appears somewhat biased.</td>
</tr>
<tr>
<td>Efficacy of Various Antidiabetic Agents as Add-On Treatments to Metformin in Type 2 DiabetesMellitus: Systematic Review and Meta-Analysis</td>
<td>Poolsup et al. [278] 2012</td>
<td>Patients: T2DM with inadequate control on metformin alone Medication/intervention: SUs, TZDs, DPP-4 inhibitors, insulin, insulin NPH, and long-acting insulin Comparisons: RCTs of combination therapy of metformin with various glycaemia lowering agents.</td>
<td>9</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Is the Combination of Sulfonylureas and Metformin Associated With an Increased Risk of Cardiovascular Disease or All-Cause Mortality? A meta-analysis of observational studies</td>
<td>Rao et al. [279] 2008</td>
<td>Patients: T2DM Medications/interventions: acetohexamide, chlorpropamide, tolbutamide, tolazamide, glyburide, glipizide, biguanides, metformin, and glimepiride. Comparisons: observational studies that examined the association between combination therapy of SUs and metformin on risk of CVD or all-cause mortality</td>
<td>25</td>
<td></td>
<td>6</td>
<td>No data on hypoglycaemia episodes in patients on GLP-1 agonists are provided.</td>
</tr>
<tr>
<td>The incidence of mild and severe hypoglycaemia in patients with type 2 diabetes mellitus treated with sulfonylureas: a systematic review and meta-analysis</td>
<td>Schopman et al. [280] 2014</td>
<td>Patients: T2DM Medications/interventions: GLP-1 agonists (liraglutide, exenatide), DPP-4 inhibitors (sitagliptin, vildagliptin and saxagliptin), SUs, insulin glargine or pre-mixed insulin Comparisons: GLP-1 agonists or DPP-4 inhibitors with SUs, insulin glargine or pre-mixed insulin</td>
<td>45</td>
<td>NO</td>
<td>4</td>
<td></td>
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<tr>
<td>Cardiovascular safety and glycemic control of GLP-1 agonists for type 2 diabetes mellitus: A pairwise and network meta-analysis</td>
<td>Sun et al. [104] 2012</td>
<td>Patients: T2DM Medications/interventions: exenatide, liraglutide, albiglutide, taspoglutide orlixisenatide Comparisons: exenatide, liraglutide, albiglutide, taspoglutide orlixisenatide vs. active comparator or placebo</td>
<td>55</td>
<td></td>
<td>9</td>
<td>Limitation: Most trials were rated as high risk of bias.</td>
</tr>
<tr>
<td>Sodium–Glucose Cotransporter 2 Inhibitors for Type 2 Diabetes A Systematic Review and Meta-analysis</td>
<td>Vasilakou et al. [281] 2013</td>
<td>Patients: T2DM Medications/Interventions: SGLT-2 inhibitors, other medication for T2DM</td>
<td></td>
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</tr>
<tr>
<td>Topic</td>
<td>Authors</td>
<td>Year</td>
<td>Study Design</td>
<td>Comparison</td>
<td>Patients</td>
<td>Medications/Interventions</td>
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<tr>
<td>GLP-1 agonists vs. insulin in inadequately controlled patients with type 2 diabetes mellitus: a meta-analysis of clinical trials</td>
<td>Wang et al. [282]</td>
<td>2011</td>
<td>RCTs</td>
<td>SGLT-2 with placebo or other medication for T2DM</td>
<td>non-pregnant adults at least 18 years of age, with T2DM for at least 3 months, suboptimally controlled with oral agents (e.g. metformin and/or SU) with HbA1c levels between 7 and 11% (53–97 mmol/mol)</td>
<td>GLP-1 agonists, insulin, e.g. glargine or biphasic insulin aspart exenatide or liraglutide with insulin</td>
</tr>
<tr>
<td>The effects of sulfonylureas plus metformin on lipids, blood pressure, and adverse events in type 2 diabetes: a meta-analysis of randomized controlled trials</td>
<td>Zhang et al. [283]</td>
<td>2013</td>
<td>RCTs</td>
<td>GLP-1 agonists (exenatide or liraglutide) with insulin</td>
<td>T2DM</td>
<td>metformin, glimepiride, glipizide, glibenclamide, gliclazide</td>
</tr>
<tr>
<td>Longer term safety of dipeptidyl peptidase-4 inhibitors in patients with type 2 diabetes mellitus: systematic review and meta-analysis</td>
<td>Goossen et al. [284]</td>
<td>2012</td>
<td>RCTs</td>
<td>DPP-4 inhibitors compared to placebo, another gliptin or any other glycaemia-lowering drug</td>
<td>T2DM</td>
<td>alogliptin, linagliptin, saxagliptin, sitagliptin, vildagliptin</td>
</tr>
</tbody>
</table>
### Chapter 2.3. Systematic reviews presenting data on all-cause and cardiovascular mortality associated with different glycaemia-lowering drugs

<table>
<thead>
<tr>
<th>Setting</th>
<th>All-cause mortality</th>
<th>Cardiovascular (CV) mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Landman et al. [255] 2014</strong></td>
<td>Patients: adults with type 2 diabetes</td>
<td>There were 12 deaths in 2500 gliclazide users and 8 deaths in the comparator group of 2569 patients, risk ratio gliclazide vs. others: 1.50 (95% CI: 0.62, 3.62).</td>
</tr>
<tr>
<td><strong>Hemmingsen et al. [264] 2013</strong></td>
<td>Patients: T2DM</td>
<td>FGSU vs. placebo: RR 1.46, 95% confidence interval (CI) 0.87 to 2.45; vs. insulin: relative risk (RR) 1.18, CI 0.88 to 1.59; SGSU vs. metformin: (RR 0.98, CI 0.61 to 1.58), SGSU vs. insulin (RR 0.96, CI 0.79 to 1.18), SGSU vs. meglitinides (RR 1.44, CI 0.47 to 4.42), SGSU vs. incretin-based interventions (RR 1.39, CI 0.52 to 3.68). Mortality data for the SGSU vs. placebo were sparse. TGSUs could not be included in any meta-analysis of all-cause mortality, CV mortality, non-fatal macro- or microvascular outcomes due to lack of data.</td>
</tr>
<tr>
<td><strong>Boussageon et al. [267] 2012</strong></td>
<td>Patients: T2DM</td>
<td>Metformin and insulin vs. insulin alone did not significantly affect all-cause mortality (RR 1.30, CI 0.57 to 2.99).</td>
</tr>
<tr>
<td><strong>Lamanna et al. [272] 2011</strong></td>
<td>Patients: T2DM</td>
<td>It is likely that metformin monotherapy is associated with improved survival (RR: 0.801 CI 0.625–1.024, p= 0.076). However, concomitant use with SUs was associated with reduced survival (RR: 1.432 CI 1.068–1.918), P= 0.016.</td>
</tr>
<tr>
<td><strong>Selvin et al. [273] 2008</strong></td>
<td>Patients: T2DM: drugs either as monotherapy (vs. placebo or vs. other oral agent) or as dual therapy (all possible combinations)</td>
<td>Metformin compared with any other oral diabetes agent or placebo: no statistically significant difference in all-cause mortality.</td>
</tr>
<tr>
<td><strong>Rao et al. [279] 2008</strong></td>
<td>Patients: T2DM</td>
<td>Combination therapy of SUs and metformin vs. other: pooled RR: 1.19 CI (0.88–1.62).</td>
</tr>
<tr>
<td><strong>Phung et al. [270] 2013</strong></td>
<td>Patients: T2DM</td>
<td>Combination therapy of SUs and metformin vs. other: pooled RR 1.43 (1.10–1.85) for a composite end point of CVD hospitalizations or mortality (fatal or nonfatal events).</td>
</tr>
<tr>
<td><strong>Sun et al. [104] 2012</strong></td>
<td>Patients: T2DM: exenatide, liraglutide, albigluthide, taspoglutide</td>
<td>Combination therapy of SUs and metformin vs. other: pooled RR 1.43 (1.10–1.85) for a composite end point of CVD hospitalizations or mortality (fatal or nonfatal events).</td>
</tr>
</tbody>
</table>

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There were 11 cases with cardiovascular events (different adults with type 2 diabetes patients: et al. [255] 2014. There were 12 deaths in 2500 gliclazide users and 8 deaths in the comparator group of 2569 patients, risk ratio gliclazide vs. others: 1.50 (95% CI: 0.62, 3.62). There were 3 cardiovascular deaths in 1602 gliclazide users and 7 in 1619 comparator patients, risk ratio gliclazide 0.95 (95% CI: 0.57, 1.61). There were 20 cases in the comparator group of 1508 patients, risk ratio for gliclazide 0.95 (95% CI: 0.57, 1.61). There were 3 cardiovascular deaths in 1602 gliclazide users and 7 in 1619 comparator patients, risk ratio gliclazide 0.95 (95% CI: 0.57, 1.61). There were 3 cardiovascular deaths in 1602 gliclazide users and 7 in 1619 comparator patients, risk ratio gliclazide 0.95 (95% CI: 0.57, 1.61). There were 3 cardiovascular deaths in 1602 gliclazide users and 7 in 1619 comparator patients, risk ratio gliclazide 0.95 (95% CI: 0.57, 1.61).
Orlistatin vs active comparator (not further specified, so unclear what this means) or placebo

Saenz et al. [262] 2005

 Patients: T2DM on monotherapy
 Comparisons: monotherapy vs. placebo, vs. alternative monotherapy or vs. diet/lifestyle intervention

Obese patients allocated to intensive blood glucose control with metformin showed a greater benefit than chlorpropamide, glibenclamide, or insulin for all-cause mortality (P = 0.03). Obese participants assigned to intensive blood glucose control with metformin showed a greater benefit than overweight patients on conventional treatment (mainly diet) for all-cause mortality (P = 0.01).

Obese patients allocated to intensive blood glucose control with metformin showed a greater benefit than chlorpropamide, glibenclamide, or insulin for any diabetes-related outcomes (P = 0.009). Obese participants assigned to intensive blood glucose control with metformin showed a greater benefit than overweight patients on conventional treatment for any diabetes-related outcomes (P = 0.004), and myocardial infarction (P = 0.02).
## Chapter 2.3. Systematic reviews presenting data on hypoglycaemic risk, HbA1c change and body weight change associated with different glycaemia-lowering drugs

<table>
<thead>
<tr>
<th>First Author</th>
<th>Protocol and drugs included</th>
<th>Hypoglycaemia risk</th>
<th>HbA1c change*</th>
<th>Body weight change</th>
</tr>
</thead>
</table>
| Landman *et al.* 2014 | **Patients:** adults with type 2 diabetes  
**Medication/intervention:** studies comparing glimepiride (either short sustained release)  
**Comparison:** with other glucose-lowering drugs; trials using placebo, diet, insulin or rosiglitazones were excluded. | There was one severe hypoglycaemic event in 2,387 glimepiride users and one in the 2,430 patients in the comparator group. There were 25 non-severe hypoglycaemic events (2.2%) in 1,152 glimepiride users and 22 hypoglycaemic events (1.8%) in 1,163 patients in the comparator group (rr 1.09 (95% CI 0.20, 5.78) after 13 to 104 weeks follow-up. | Compared to all other interventions, glimepiride was more effective: 20.12% (95%CI: 20.23, 20.01). Compared to metformin monotherapy, the effect estimate of glimepiride monotherapy was 0.26 (95%CI: 20.59, 1.11; I2 0%). | The difference in weight was 0.47 kg (95% CI 20.75, 1.70) in favor of the control group (I2 87%). When comparing glimepiride to metformin the effect estimate was 1.37 kg (95%CI 0.15, 2.60, I2 28%). |
| Bennett *et al.* 2009 | **Patients:** T2DM  
**Comparison:** as monotherapy and in combination | SU had a higher risk for mild or moderate hypoglycaemia than metformin alone (RR 4.6, CI 3.2–6.5) and, in combination with metformin, an increased risk compared with metformin plus TZDs (RR 5.8, CI 4.3–7.7). The RR for meglitinide monotherapy and meglitinide plus metformin was 3.0 (CI 1.8–5.2) and compared to metformin monotherapy 2.7 (CI 1.0–7.7). Metformin plus DDP4-I had no higher risk for hypoglycaemia than metformin monotherapy (RR 0.9, CI 0.4 to 2.4). | Evidence supports metformin as a first-line agent to treat T2DM. Most 2-drug combinations similarly reduce hemoglobin A1c levels, but some increased risk for hypoglycaemia and other adverse events. Mean Difference in HbA1c Level (CI), Met vs. SU: 0.07 (–0.12 to 0.26); SU vs. Meg: 0.07 (–0.15 to 0.29); Met vs. TZD: –0.07 (–0.18 to 0.04); TZD vs. SU: –0.10 (–0.22 to 0.01); Met vs. DPP-4 inhibitor: –0.37 (–0.54 to –0.20); Met vs. Met + SU: 1.00 (0.75 to 1.25); Met vs. Met + DPP-4 inhibitor: 0.69 (0.56 to 0.82); Met vs. Met+TZD: 0.66 (0.45 to 0.86); Met+basal vs. Met+premixed: 0.30 (–0.26 to 0.86) Met+TZD vs. Met+SU:–0.06 (–0.17 to 0.06); Met+SU vs. TZD+SU:–0.09 (–0.19 to 0.01). | Metformin decreased weight compared with TZDs and SU. SUs and meglitinides increased weight similarly, SUs increased weight less than TZDs, and GLP-1 agonists decreased weight compared with SUs. Combinations of metformin plus a TZD or metformin plus a SU increased weight more than metformin monotherapy. The combination of metformin plus a DPP-4 inhibitor compared with metformin alone affected weight similarly. Weight gain was slightly less with metformin plus SU than with either metformin plus a TZD or a TZD plus a SU. Reduction in weight was greater with metformin plus a GLP-1 agonist than with most standard combinations, although few studies used the same comparators and therefore the strength of evidence was low. Weight change in kg (CI): SU vs. GLP-1: 2.5 (1.2 to 3.8); TZD vs. SU: 1.2 (0.6 to 1.9); SU vs. Meg: 0.0 (–1.0 to 1.0); Met vs. DPP-4 inhibitor: –1.4 (–1.8 to –1.0); Met vs. TZD: –2.6 (–4.1 to –1.2); Met vs. SU: –2.7 (–3.5 to –1.9); Met vs. Met+DPP-4 inhibitor: –0.2 (–0.7 to 0.2); Met vs. Met+TZD: –2.2 (–2.6 to –1.9); Met vs. Met + SU: –2.3 (–3.3 to –1.2); Met + TZD vs. Met + SU: 0.9 (0.4 to 1.3); Met + basal vs. Met + premixed: –1.8 (–7.8 to 4.2); Met + SU vs. TZD + SU: –3.2 (–5.2 to –1.1). |
| Poolsup *et al.* 2012 | **Patients:** T2DM poorly treated on metformin alone  
**Comparison:** RCTs of combination therapy of metformin with various glycaemia-lowering agents | DPP-4 inhibitors were associated with a lower risk of hypoglycaemia than SUs (RR 0.10, CI 0.07–0.13, p &lt; 0.01; 3 trials), whereas no significant difference was observed in comparisons with metformin (RR DPP-4 inhibitors were associated with a lower risk of hypoglycaemia than SUs (RR 0.10, CI 0.07–0.13, p &lt; 0.01; 3 trials), whereas no significant difference was observed in comparisons with metformin (RR DPP-4 inhibitors were associated with a lower risk of hypoglycaemia than SUs (RR 0.10, CI 0.07–0.13, p &lt; 0.01; 3 trials), whereas no significant difference was observed in comparisons with metformin (RR DPP-4 inhibitors were associated with a lower risk of hypoglycaemia than SUs (RR 0.10, CI 0.07–0.13, p &lt; 0.01; 3 trials), whereas no significant difference was observed in comparisons with metformin (RR DPP-4 inhibitors were associated with a lower risk of hypoglycaemia than SUs (RR 0.10, CI 0.07–0.13, p &lt; 0.01; 3 trials), whereas no significant difference was observed in comparisons with metformin. | TZDs reduced as effectively as DPP-4 inhibitors. HbA1c value (pooled mean difference –0.03%, CI –0.16 to 0.10%). TZDs vs. SU: no difference in reduction of HbA1c. |
| Monami *et al.* 2011 | **Patients:** T2DM  
**Comparison:** DPP-4 inhibitors vs other oral drugs or insulin or placebo as monotherapy | DPP-4 inhibitors were associated with a lower risk of hypoglycaemia than SUs (RR 0.10, CI 0.07–0.13, p &lt; 0.01; 3 trials), whereas no significant difference was observed in comparisons with metformin (RR DPP-4 inhibitors were associated with a lower risk of hypoglycaemia than SUs (RR 0.10, CI 0.07–0.13, p &lt; 0.01; 3 trials), whereas no significant difference was observed in comparisons with metformin (RR DPP-4 inhibitors were associated with a lower risk of hypoglycaemia than SUs (RR 0.10, CI 0.07–0.13, p &lt; 0.01; 3 trials), whereas no significant difference was observed in comparisons with metformin (RR DPP-4 inhibitors were associated with a lower risk of hypoglycaemia than SUs (RR 0.10, CI 0.07–0.13, p &lt; 0.01; 3 trials), whereas no significant difference was observed in comparisons with metformin. | In the 14 trials with available data, DPP-4 inhibitors produced a significant increase of BMI at 21–30 weeks (0.10 kg/m², CI 0.05–0.15, P &lt;0.001). In active... |
<table>
<thead>
<tr>
<th>Monami et al. [257] 2008</th>
<th>Patients: T2DM with inadequate glycaemic control on metformin</th>
<th>Comparison: metformin plus placebo vs. plus other drugs or head to head comparisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black et al. [258] 2009</td>
<td>Patients: T2DM</td>
<td>Comparisons: meglitinide analogues to placebo, head-to-head, metformin or in combination with insulin</td>
</tr>
<tr>
<td>Hirst et al. [259] 2013</td>
<td>Patients: T2DM</td>
<td>Comparison: fixed-dose SU monotherapy or SU added on to other glucose-lowering treatments (metformin, insulin or TZD)</td>
</tr>
<tr>
<td>Richter et al. [118] 2008</td>
<td>Patients: T2DM</td>
<td>Comparisons: sitagliptin or vildagliptin vs. placebo; sitagliptin or vildagliptin vs. single hypoglycaemic agents; sitagliptin or vildagliptin in combination with other hypoglycaemic agents vs. other combinations of hypoglycaemic agents; sitagliptin or vildagliptin vs. intensive lifestyle interventions</td>
</tr>
<tr>
<td>Saenz et al. [262] 2005</td>
<td>Patients: T2DM on monotherapy</td>
<td>Comparisons: monotherapy vs. placebo or vs. alternative monotherapy or vs. diet/lifestyle intervention</td>
</tr>
<tr>
<td>Shyangdan Deepson et al.</td>
<td>Patients: T2DM</td>
<td>Comparisons: placebo, TZD, DPP-4</td>
</tr>
</tbody>
</table>

Reduction of HbA1c with SUs, TZDs, and α-glucosidase inhibitors, was 0.85% (CI 0.78–0.94), 0.42% (CI 0.40–0.44) and 0.61% (CI 0.55–0.67) respectively.

When compared to metformin monotherapy, both repaglinide and nateglinide produce a similar reduction in HbA1c than metformin. The combination of metformin with a meglitinide produced a clinically significant additional reduction in HbA1c when compared to metformin monotherapy.

Metrin in combination with insulin was more effective in reducing HbA1c than repaglinide in combination with insulin.

SU monotherapy lowered HbA1c level more than previously reported (-1.51%, CI -1.78 to -1.25). SU added to another oral glycaemia-lowering agent resulted in a mean HbA1c change of -1.62% (CI: -2.24 to -1.00) and to insulin -0.46% (CI -0.02–0.13, P = 0.18).

For both repaglinide and nateglinide, in almost all studies where weight was reported, weight gains occurred. Where meglitinides were compared directly to metformin, those treated with metformin experienced the greater weight losses.

When compared to metformin monotherapy, both repaglinide and nateglinide produce a similar reduction in HbA1c than metformin. The combination of metformin with a meglitinide produced a clinically significant additional reduction in HbA1c when compared to metformin monotherapy.

Metrin in combination with insulin was more effective in reducing HbA1c than repaglinide in combination with insulin.

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For both repaglinide and nateglinide, in almost all studies where weight was reported, weight gains occurred. Where meglitinides were compared directly to metformin, those treated with metformin experienced the greater weight losses.

Both exenatide and liraglutide led to greater weight loss than most active comparators.
<table>
<thead>
<tr>
<th>First Author</th>
<th>Protocol and drugs included</th>
<th>Hypoglycaemia risk</th>
<th>HbA1c change*</th>
<th>Body weight change</th>
</tr>
</thead>
<tbody>
<tr>
<td>[260] 2013</td>
<td>inhibitors, insulin glargine, SU, other GLP-1 agonist</td>
<td>Severe hypoglycaemia occurred in two patients (13%) in the metformin group and one participant (7%) in the control group, while mild hypoglycaemia occurred more frequently in the metformin than in the placebo group after three months of therapy: mean 1.75 (0.8) vs. 0.9 (0.4) events/patient/week, respectively (P = 0.03) (one study)</td>
<td>2 mg once weekly and liraglutide 1.8 mg reduced it by 0.20% and 0.24% respectively more than insulin glargine. Exenatide 2 mg once weekly reduced HbA1c more than exenatide 10 μg twice daily. Sitagliptin and pioglitazone. Liraglutide 1.8 mg reduced HbA1c by 0.33% (4 mmol/mol) more than exenatide 10 μg twice daily. Liraglutide led to similar improvements in HbA1c compared to SUs but reduced it more than sitagliptin and rosiglitazone.</td>
<td>Including in participants not experiencing nausea</td>
</tr>
<tr>
<td>Abdelghaffar et al. [261] 2009</td>
<td>Patients: patients with Type 1 diabetes Comparisons: metformin as add-on to insulin vs. insulin alone</td>
<td>Severe hypoglycaemia occurred in two patients (13%) in the metformin group and one participant (7%) in the control group, while mild hypoglycaemia occurred more frequently in the metformin than in the placebo group after three months of therapy: mean 1.75 (0.8) vs. 0.9 (0.4) events/patient/week, respectively (P = 0.03) (one study)</td>
<td>Metformin treatment lowered HbA1c in adolescents with type 1 diabetes and poor metabolic control.</td>
<td>Improvements in body composition were not documented in either study.</td>
</tr>
<tr>
<td>Karagiannis et al. [119] 2012</td>
<td>Patients: T2DM Comparisons: DPP-4 inhibitors vs. metformin as monotherapy or with a SU, pioglitazone, a GLP-1 agonist, or basal insulin combined with metformin</td>
<td>Across all studies analysed, severe hypoglycaemia (defined as an episode that required the help of another person) occurred in six patients receiving a DPP-4 inhibitor (n=6615). In the control groups, one patient receiving metformin as monotherapy (n=1647), 51 receiving a SU (n=3873), one patient receiving a GLP-1 agonist (n=381), and none of the 445 patients receiving pioglitazone experienced at least one episode of severe hypoglycaemia.</td>
<td>Compared with metformin as monotherapy, DPP-4 inhibitors were associated with a smaller decline in HbA1c (weighted mean difference 0.20%, CI 0.08 to 0.32). As a second line treatment, DPP-4 inhibitors were inferior to GLP-1 agonists (0.49%, CI 0.31 to 0.67) in reducing HbA1c and had no advantage over SUs in the attainment of the HbA1c goal (RR in favour of SUs 1.06, CI 0.98 to 1.14).</td>
<td>DPP-4 inhibitors had a favourable weight profile compared with SUs (weighted mean difference −1.92, CI −2.34 to −1.49) but not compared with GLP-1 agonists (1.56, CI 0.94 to 2.18).</td>
</tr>
<tr>
<td>Van De Laar et al. [266] 2009</td>
<td>Patients: T2DM Comparisons: α-glucosidase inhibitor monotherapy vs. all other interventions</td>
<td>SGSU vs. meglitinides showed no statistical significance for the risk of severe hypoglycaemia. SGSU vs. metformin showed statistical significance in favour of metformin (RR 3.64, CI 1.22–26.0) for severe hypoglycaemia.</td>
<td>The achieved percentage of HbA1c decreased with metformin and insulin compared with insulin alone (mean difference −0.60%, CI −0.89 to −0.31, P&lt;0.001, 20 trials; Significant heterogeneity I^2=82%, P&lt;0.001). Trial sequential analyses showed sufficient evidence for a HbA1c reduction of 0.5% with metformin+insulin vs. insulin alone</td>
<td>Both body mass index and weight gain were significantly reduced by metformin and insulin compared with insulin alone (body mass index: mean difference −1.27, CI −2.07 to −0.47, P=0.002, 6 trials (Significant heterogeneity I^2=86%, P&lt;0.001); weight gain: −1.68 kg, CI −2.22 to −1.13, P&lt;0.001, 13 trials (I^2=36%, P=0.09). A trial sequential analysis showed sufficient evidence for a lower weight gain of 1 kg with metformin+insulin vs. insulin alone.</td>
</tr>
<tr>
<td>Hemmingsen et al. [285] 2013</td>
<td>Patients: T2DM Comparisons: SU monotherapy vs. placebo, no intervention or other glycaemia-lowering interventions</td>
<td>SGSU vs. meglitinides showed no statistical significance for the risk of severe hypoglycaemia. SGSU vs. metformin showed statistical significance in favour of metformin (RR 3.64, CI 1.22–26.0) for severe hypoglycaemia.</td>
<td>The achieved percentage of HbA1c decreased with metformin and insulin compared with insulin alone (mean difference −0.60%, CI −0.89 to −0.31, P&lt;0.001, 20 trials; Significant heterogeneity I^2=82%, P&lt;0.001). Trial sequential analyses showed sufficient evidence for a HbA1c reduction of 0.5% with metformin+insulin vs. insulin alone</td>
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</tr>
<tr>
<td>Hemmingsen et al. [265] 2012</td>
<td>Patients: T2DM Comparisons: to compare the benefits and harms of metformin and insulin vs. insulin alone</td>
<td>In a fixed effect model, but not in a random effects model, severe hypoglycaemia was significantly more frequent with metformin and insulin than with insulin alone (RR 2.83, CI 1.17–6.86).</td>
<td>The achieved percentage of HbA1c decreased with metformin and insulin compared with insulin alone (mean difference −0.60%, CI −0.89 to −0.31, P&lt;0.001, 20 trials; Significant heterogeneity I^2=82%, P&lt;0.001). Trial sequential analyses showed sufficient evidence for a HbA1c reduction of 0.5% with metformin+insulin vs. insulin alone</td>
<td>Both body mass index and weight gain were significantly reduced by metformin and insulin compared with insulin alone (body mass index: mean difference −1.27, CI −2.07 to −0.47, P=0.002, 6 trials (Significant heterogeneity I^2=86%, P&lt;0.001); weight gain: −1.68 kg, CI −2.22 to −1.13, P&lt;0.001, 13 trials (I^2=36%, P=0.09). A trial sequential analysis showed sufficient evidence for a lower weight gain of 1 kg with metformin+insulin vs. insulin alone.</td>
</tr>
</tbody>
</table>
### Bolen et al. [121] 2007

**Patients:** T2DM  
**Comparisons:** all possible combinations, also with placebo

| Comparison | RR (CI) | Hypoglycaemia
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Met vs. Met + TZD</td>
<td>0.00 (−0.01 to 0.01)</td>
<td>SU vs. repag: 0.02 (−0.02 to 0.05); glyb vs. other SU: 0.03 (0.00 to 0.05); SU vs. Met: 0.04 (0.00 to 0.09); SU + TZD vs. SU: 0.08 (0.00 to 0.16); SU vs. TZD: 0.09 (0.03 to 0.15); SU + Met vs. SU: 0.11 (0.07 to 0.14); SU + Met vs. Met: 0.14 (0.07 to 0.21)</td>
</tr>
<tr>
<td>TZD vs. Met</td>
<td>1.9 (0.5 to 3.3)</td>
<td></td>
</tr>
<tr>
<td>TZD vs. SU</td>
<td>1.1 (1.0 to 1.0)</td>
<td></td>
</tr>
<tr>
<td>SU vs. Met + SU</td>
<td>0.05 (0.00 to 0.16); Met + SU vs. SU: 0.08 (0.05 to 0.14)</td>
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</tbody>
</table>

### Zhu et al. [268] 2013

**Patients:** T2DM  
**Comparisons:** metformin vs. glimipiride vs. placebo as monotherapy

- Higher risk of hypoglycaemia with glimipiride

### Phung et al. [270] 2013

**Patients:** T2DM  
**Comparisons:** clinical and observational studies that reported the association between SU and CVD events as compared to other glycaemia-lowering drugs

- Hypoglycaemia risk increased with combination therapy: RR 1.36 (CI 1.08–2.26). Drugs combined with metformin included TZDs, insulin secretagogues, DPP-4 inhibitors or SGLT-2 inhibitors.

### Phung et al. [122] 2010

**Patients:** T2DM experiencing an inadequate response to maximized and stable (4 weeks at 1500 mg or maximally tolerated dose) metformin therapy  
**Comparisons:** drugs added to metformin, head to head or vs. placebo

- Compared to metformin alone, combination therapy with metformin resulted in reductions in HbA1c (−0.43%, CI −0.56 to −0.30), increases in attainment of HbA1c goal of less than 7% (53 mmol/mol) (RR 1.40, CI 1.33–1.48).

- The different classes of drugs were associated with similar HbA1c reductions (range 0.64%–0.97%) compared with placebo.

### McIntosh et al. [120] 2011

**Patients:** adults and children with T2DM requiring a second-line glycaemia-lowering agent because of inadequate control (HbA1c > 6.5% (46 mmol/mol), FPG > 7 mmol/L or PPG > 10 mmol/L) on metformin monotherapy or because of intolerance to this therapy  
**Comparisons:** drugs were associated to metformin or replaced metformin

- Relative to metformin monotherapy, RR (CI) was significantly elevated with SU 8.28 (4.5–16.63), meglitinides 8.59 (3.34–25.2), basal insulin 5.20 (1.48–21.46) and biphasic insulin 11.02 (3.48–40.43), but not with TZDs 1.10 (0.52–2.27), DPP-4 inhibitors 1.05 (0.56–2.21), β-glucosidase inhibitors 0.39 (0.01–6.67) or GLP-1 agonists 1.12 (0.33–3.90).

### McIntosh et al. [124] 2012

**Patients:** patients with T2DM, inadequately controlled on metformin/SU combination therapy  
**Comparisons:** comparative safety and efficacy of all available classes of glycaemia-lowering therapies as add-on to combination metformin+SU

- Treatment regimens containing insulin were associated with increased hypoglycaemia relative to comparators, but severe hypoglycaemia was rare across all treatments.  
  
<table>
<thead>
<tr>
<th>RR (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basal insulin + Met + SU vs. placebo + Met + SU: 2.03 (1.15–3.58); TZD + Met + SU vs. placebo + Met + SU: 5.62 (2.81–11.25); DPP-4 inhibitor + Met + SU vs. placebo + Met + SU: 21.94 (2.88–167); GLP-1 + Met + SU vs. placebo + Met + SU: 2.07 (1.54–2.77); biphasic insulin + Met + SU vs. basal insulin + Met + SU: 4.01 (2.31–6.96); biphasic insulin + Met + SU vs. basal insulin + Met + SU: 1.29 (0.90–1.86); TZD + Met + SU vs. basal insulin + Met + SU: 0.40 (0.21–0.75); GLP-1 + Met + SU vs. basal insulin + Met + SU: 0.93</td>
</tr>
</tbody>
</table>
  | DMP-4 inhibitors, GLP-1 agonists and TZDs (TZDs) produced statistically significant reductions in HbA1c in combination with metformin and a SU (−0.89% to −1.17%), whereas meglitinides and α-glucosidase inhibitors did not.  
  | Biphasic insulin, bolus insulin, and TZDs were associated with weight gain (1.85–3.90 kg), whereas DPP-4 inhibitors and α-glucosidase inhibitors were weight-neutral, and GLP-1 agonists (0.6 to −1.8 kg).  

**Patients:** T2DM experiencing an inadequate response to maximized and stable (4 weeks at 1500 mg or maximally tolerated dose) metformin therapy

- Compared to metformin monotherapy, RR (CI) was significantly elevated with SU 8.28 (4.5–16.63), meglitinides 8.59 (3.34–25.2), basal insulin 5.20 (1.48–21.46) and biphasic insulin 11.02 (3.48–40.43), but not with TZDs 1.10 (0.52–2.27), DPP-4 inhibitors 1.05 (0.56–2.21), β-glucosidase inhibitors 0.39 (0.01–6.67) or GLP-1 agonists 1.12 (0.33–3.90).

- Although use of TZDs, SUs, and glinides were associated with weight gain (range, 1.77–2.08 kg), GLP-1 agonists, α-glucosidase inhibitors, and DPP-4 inhibitors were associated with weight loss or no weight change.

- An increase in body weight was observed with the majority of second-line therapies (1.8 to 3.0 kg), the exceptions being DPP-4 inhibitors, α-glucosidase inhibitors and GLP-1 agonists (0.6 to −1.8 kg).

**Comparisons:** all possible combinations, also with placebo

- Glyb vs. other SU:−0.03 (−0.13 to 0.07); TZD vs. SU: −0.05 (−0.13 to 0.02); TZD vs. Met: −0.04 (−0.23 to 0.15); repag vs. SU: −0.06 (−0.30 to 0.18); SU vs. Met: −0.09 (−0.30 to 0.10); SU vs. acarbose: −0.38 (−0.77 to 0.02); Met + TZD vs. Met: −0.62 (−1.0 to −0.23); SU + TZD vs. SU: −1.0 (−1.30 to −0.69); Met + SU vs. Met: −1.0 (−1.34 to −0.76); Met + SU vs. SU: −1.0 (−1.34 to −0.67)

- SU vs. Met: 3.5 (3.0 to 4.0)  
  Met + SU vs. Met: 2.4 (1.1 to 3.6)  
  SU vs. Met: 1.9 (1.4 to 2.4)  
  TZD vs. Met: 1.9 (0.5 to 3.3)  
  SU vs. acarbose: 1.9 (0.2 to 4.0)  
  TZD vs. SU: 1.1 (−0.9 to 3.1)  
  SU vs. Met + SU: 0.05 (−0.5 to 0.6)  
  SU vs. repag: 0.03 (−1.0 to 1.0)
<table>
<thead>
<tr>
<th>First Author</th>
<th>Protocol and drugs included</th>
<th>Hypoglycaemia risk</th>
<th>HbA1c change*</th>
<th>Body weight change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross et al. [125] 2011</td>
<td>Patients: adults aged 18 years or older with T2DM and a HbA1c level greater than 7.0% (53 mmol/mol) who were already receiving a combination of metformin and a SU</td>
<td>Insulins caused twice the absolute number of severe hypoglycaemic episodes than noninsulin antihyperglycaemic agents.</td>
<td>Compared with placebo, drug classes did not differ in effect on HbA1c level (reduction ranging from 0.70% (credible interval (CrI) 1.33 – 0.08%) for acarbose to 1.08% (CrI 1.41 – 0.77%) for insulin).</td>
<td>Compared with placebo, weight loss was seen with GLP-1 agonists (1.63 kg (CrI 2.71 – 0.60 kg)).</td>
</tr>
<tr>
<td>Phung et al. [122] 2010</td>
<td>Patients: T2DM experiencing an inadequate response to maximized and stable (4 weeks at 1500 mg or maximally tolerated dose) metformin therapy</td>
<td>In mixed-treatment comparison meta-analysis, SU (RR, 4.57, CrI, 2.11 – 11.45) and glinide (RR, 7.50, CrI, 2.12 – 41.52) treatments were associated with increased risk of hypoglycaemia compared with placebo. TZDs (RR, 0.56, CrI, 0.19 – 1.69), α-glucosidase inhibitors (RR, 0.42, CrI, 0.01 – 9.00), DPP-4 inhibitors (RR, 0.63, CrI, 0.26 – 1.71), and GLP-1 analogues (RR, 0.89; CrI, 0.22 – 3.96) were not associated with increased risk of hypoglycaemia compared with placebo.</td>
<td>Mean (SD) HbA1c decrease: insulin basal: –1.28 (0.36); biphasic –1.91 (0.64); prandial –1.08 (0.68); basal bolus –1.22 (0.58); GLP-1 agonists –1.12 (0.23); exenatide LAR –1.61 (0.16); DPP-4 inhibitors –0.74 (0.30); α-glucosidase Inhibitor –0.72 (0.41); SUs –0.77 (0.29); glinides –0.64 (0.20); metformin –1.21 (0.48); Percentage attaining &lt;7% (53 mmol/mol) HbA1c (CI): insulin basal 38.9 (35.7 – 42.2); biphasic 34.4 (31.1 – 37.9); prandial 36.3 (26.3 – 47.7); basal bolus 50.2 (43.0 – 57.4); GLP-1 agonists 45.7 (42.2 – 49.2);</td>
<td></td>
</tr>
<tr>
<td>Esposito et al. [274] 2012</td>
<td>Patients: T2DM</td>
<td>Mean (SD) HbA1c decrease: insulin basal: –1.28 (0.36); biphasic –1.91 (0.64); prandial –1.08 (0.68); basal bolus –1.22 (0.58); GLP-1 agonists –1.12 (0.23); exenatide LAR –1.61 (0.16); DPP-4 inhibitors –0.74 (0.30); α-glucosidase Inhibitor –0.72 (0.41); SUs –0.77 (0.29); glinides –0.64 (0.20); metformin –1.21 (0.48); Percentage attaining &lt;7% (53 mmol/mol) HbA1c (CI): insulin basal 38.9 (35.7 – 42.2); biphasic 34.4 (31.1 – 37.9); prandial 36.3 (26.3 – 47.7); basal bolus 50.2 (43.0 – 57.4); GLP-1 agonists 45.7 (42.2 – 49.2);</td>
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</tbody>
</table>
| Amori et al. [113] 2007 | Patients: T2DM  
Comparison: Monotherapy and add-on therapy were considered |
|------------------------|-------------------------------------------------|
| Aroda et al. [275] 2012 | Patients:  
Comparisons:  
- monotherapy vs. placebo  
- single vs. another glycaemia-lowering agent as single add-on vs. placebo or vs. other glycaemia-lowering agent |
| Liu et al. [123] 2012 | Patients: T2DM who showed inadequate response to metformin monotherapy at randomisation [mean HbA1c ≥7.0% (53 mmol/mol)].  
Comparison: glycaemia-lowering agents with either a placebo or another class of glycaemia-lowering agents in addition to metformin; for at least 12 weeks, but no more than 52 weeks. Trials were excluded if they stopped metformin use or changed the metformin dose after randomisation |
| Belsey et al. [276] 2008 | Patients: T2DM inadequately controlled on metformin  
Comparisons: metformin+placebo vs. metformin plus SU. Other combinations of glycaemia-lowering drugs and combination of metformin and SU |
| Craddy et al. [277] 2014 | Patients: T2DM with inadequate glycemic control  
Comparisons: via meta-analysis DPP-4 inhibitors were compared as monotherapy, dual therapy (plus metformin, SU, pioglitazone, or insulin), and triple therapy (plus metformin/SU) |

| exenatide LAR 63.2 (54.1–71.5); DPP-4 inhibitors 39.0 (35.7–42.3); α-glucosidase inhibitors 25.9 (18.5–34.9); SUs; 48.2 (43.0–53.5); glinides 39.1 (29.3–49.9); metformin 42.0 (35.5–48.9) |

| Amori et al. 2007 | Patients: T2DM  
Comparison: Monotherapy and add-on therapy were considered |
|------------------------|-------------------------------------------------|
| Aroda et al. 2012 | Patients:  
Comparisons:  
- monotherapy vs. placebo  
- single vs. another glycaemia-lowering agent as single add-on vs. placebo or vs. other glycaemia-lowering agent |
| Liu et al. 2012 | Patients: T2DM who showed inadequate response to metformin monotherapy at randomisation [mean HbA1c ≥7.0% (53 mmol/mol)].  
Comparison: glycaemia-lowering agents with either a placebo or another class of glycaemia-lowering agents in addition to metformin; for at least 12 weeks, but no more than 52 weeks. Trials were excluded if they stopped metformin use or changed the metformin dose after randomisation |
| Belsey et al. 2008 | Patients: T2DM inadequately controlled on metformin  
Comparisons: metformin+placebo vs. metformin plus SU. Other combinations of glycaemia-lowering drugs and combination of metformin and SU |
| Craddy et al. 2014 | Patients: T2DM with inadequate glycemic control  
Comparisons: via meta-analysis DPP-4 inhibitors were compared as monotherapy, dual therapy (plus metformin, SU, pioglitazone, or insulin), and triple therapy (plus metformin/SU) |

Hypoglycaemia with glucose ≤3.1 mmol/L or ≤2.8 mmol/L was experienced by 10.1% (CI 7.3–13.8%) and 5.9% (CI 4.6–0.52).

GLP-1 agonists resulted in weight loss (1.4 kg and 4.8 kg vs. placebo and insulin, respectively) while DPP-4 inhibitors were weight neutral.

Mean weight change was seen with SUs, glinides, TZDs, basal insulin and biphasic insulin, and weight loss was seen with α-glucosidase inhibitors and GLP-1 agonists.

Mean weight change ranged from +2.5 to -0.1 kg, depending on the comparator (RR 5.3, CI 1.7–11.98) vs. 2.17 (CI 1.56–2.95).
<table>
<thead>
<tr>
<th>First Author</th>
<th>Protocol and drugs included</th>
<th>Hypoglycaemia risk</th>
<th>HbA1c change*</th>
<th>Body weight change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schopman et al.</td>
<td>inhibitors with SUs, insulin glargine or pre-mixed insulin</td>
<td>2.5–13.4% of patients with any SU treatment. Severe hypoglycaemia was experienced by 0.8% (CI 0.5–1.3%) of patients. Hypoglycaemia with glucose ≤3.1 mmol/L and severe hypoglycaemia occurred least frequently with gliclazide: in 1.4% (CI 0.8–2.4%) and 0.1% (CI 0–0.7%) of patients, respectively. Too few studies had insulin as comparator, so these data could not be meta-analysed. No data on hypoglycaemia episodes in patients on GLP-1 agonists are provided.</td>
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<tr>
<td>Vasilakou et al.</td>
<td>Patients: patients with Type 2 diabetes</td>
<td>The RR for any hypoglycaemia with SGLT-2 inhibitors was 1.28 (CI 0.99–1.65) compared with placebo and 0.44 (CI 0.35–0.54 compared with other glycaemia-lowering medications. However, exclusion of one SU-controlled study in a post hoc sensitivity analysis resulted in similar hypoglycaemic risk compared with other glycaemia-lowering agents and removed heterogeneity (OR, 1.01, CI 0.77–1.32). Across all studies analyzed, severe hypoglycaemia (defined as an episode requiring assistance from another person) was rare in all treatment groups and was seen primarily in participants already receiving a SU. SGLT-2 inhibitors had a favourable effect on HbA1c: mean difference vs. placebo 0.66% (CI 0.73–0.58%); mean difference vs. active comparators 0.06% (CI 0.18–0.05%).</td>
<td>Compared with other agents, SGLT-2 inhibitors reduced body weight (mean difference 1.80 kg [CI 3.50–11 kg])</td>
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<tr>
<td>Wang et al.</td>
<td>Patients: non-pregnant adults at least 18 years of age, with T2DM for at least 3 months, suboptimally controlled with oral agents (e.g. metformin and/or SU) with HbA1c levels between 7 and 11% (53–97 mmol/mol)</td>
<td>Overall, hypoglycaemia was reported less in the GLP-1 group, (RR 0.45, CI 0.2–0.76, P &lt; 0.01), while there was no significant difference in occurrence of severe hypoglycaemia (0.65, CI 0.29–1.45, P= 0.29). Hypoglycaemia was more frequent among patients treated with SUs plus metformin than metformin alone (RR = 6.79, CI 3.79–12.17). The RR of hypoglycaemia for DPP-4 inhibitor was 0.92 (CI 0.74, 1.15) compared to placebo and 0.20 (CI 0.17–0.24) compared to SUs in the absence of SU or insulin co-therapy. It was significantly elevated for combination therapy of SU or insulin with sitagliptin or linaclotide (RR 1.86, CI 1.46–2.37 compared to placebo).</td>
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<tr>
<td>Zhang et al.</td>
<td>Patients: T2DM</td>
<td>The mean net change (CI) for HbA1c, weight loss and FPG for patients treated with GLP-1 agonists as compared with insulin was −0.14%, (CI −0.27 to −0.02, P= 0.03); −4.40 kg, (CI −5.23 to −3.56, P &lt; 0.01) and 1.18 mmol/l (CI 0.43–1.93, p &lt;0.01) respectively.</td>
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<tr>
<td>Goossen et al.</td>
<td>Patients: T2DM</td>
<td>Compared with metformin monotherapy, DPP-4 inhibitor monotherapy was associated with lower reduction in HbA1c level (WMD=0.28%, CI 0.17–0.40, p&amp;lte;0.0001). Compared with metformin monotherapy, DPP-4 inhibitors plus metformin as initial combination therapy was associated with greater reduction in HbA1c level (WMD = −0.49 CI −0.57 to −0.40, p&amp;lte;0.0001).</td>
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<tr>
<td>Wu et al.</td>
<td>Patients: T2DM</td>
<td>Compared with metformin monotherapy, DPP-4 inhibitor monotherapy was associated with lower weight loss (WMD=0.44, CI 0.22–0.67, p=0.0001).</td>
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</table>
### Chapter 2.3. Systematic review of case reports on metformin associated lactic acidosis

<table>
<thead>
<tr>
<th>Author &amp; year</th>
<th>No. of reported cases</th>
<th>Manifestations</th>
<th>Cause of metformin overload</th>
<th>Dose/serum level of metformin (mcg/mL)</th>
<th>Relevant comorbidities and medication</th>
<th>Renal function</th>
<th>Cause of AKI (if applicable)</th>
<th>Casual relationship?</th>
<th>Lactate level (mmol/l)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perrone et al. [286] 2011</td>
<td>Case 1: 40 years, F, Case 2: 69 years, F, Case 3: 57 years, F</td>
<td>Case 1: unremarkable except mild lethargy, BP = 126/49 mmHg, HR = 79 b/min. Within 8 h of her arrival, the patient vomited multiple times and had become more lethargic. Case 2: Kussmaul respiration, dry mucous membranes, diffuse rhonchi, mild abdominal tenderness. Oral temperature 36.2°C, BP = 151/85 mm Hg, HR 100 beats/min, 32 breaths/min. Case 3: complaint of dyspnea</td>
<td>Case 1: suicide attempt Case 2: UTR Case 3: UTR started 3 days before</td>
<td>Case 1: serum level=150 Case 2: SL=27.4 Case 3: NS</td>
<td>Case 1: overdose of sertraline, risperidone, hydrochlorothiazide and metformin/ glyburide Case 2: amiodarone, valsartan, chlorthalidone, gabapentin, atorvastatin,amlodipine, furosemide,omeprazole,metformin/ glyburide multiple conditions</td>
<td>Case 1: NS Case 2: ESRD Case 3: ESRD</td>
<td>-</td>
<td>Most likely</td>
<td>Case 1: 21 Case 2: 18.9 Case 3: 16</td>
<td>Case 1: death Case 2: survived Case 3: death</td>
</tr>
<tr>
<td>Aperis et al. [287] 2011</td>
<td>Case 1: 74 years, M</td>
<td>Zoster-like abdominal pain, tachypnea, nausea and vomiting, hypotension, tachycardia, dehydration and oliguria</td>
<td>UTR NS</td>
<td>HIV infection, CAD Tenofovir, Emtricitabine, Efavirenz</td>
<td>AKI</td>
<td></td>
<td>Probably, Metformin is antiretroviral treatment</td>
<td>NS, just LA</td>
<td>Survived</td>
<td></td>
</tr>
<tr>
<td>Gamst et al. [288] 2010</td>
<td>Case 1: 61 years, M</td>
<td>NS</td>
<td>Obesity</td>
<td>NS</td>
<td></td>
<td></td>
<td>Maybe, MALA should be suspected in therapy-resistant LA</td>
<td>NS, just severe LA after resuscitation</td>
<td>Death</td>
<td></td>
</tr>
<tr>
<td>Dell’Aglio et al. [289] 2010</td>
<td>Case 1: 40 years, F</td>
<td>At arrival: awake; soon hypotensive (91/54 mm Hg) and somnolent</td>
<td>Suicide attempt</td>
<td>75–100 g ingested metformin; SL=160</td>
<td>NS</td>
<td>AKI (Crea rose from 1.5 mg/dL to 2.0 mg/dL 2.3 mg/dL at discharge)</td>
<td>Metformin-induced hypoperfusion</td>
<td>Most likely</td>
<td>40</td>
<td>Survived</td>
</tr>
<tr>
<td>Arroyo et al. [290] 2010</td>
<td>Case 1: 49 years, F</td>
<td>Presented 1 hour after ingestion, awake and alert</td>
<td>Suicide attempt</td>
<td>30 g of ingested metformin; SL=380</td>
<td>Multiple coronary stenting, hypertension, atrial fibrillation</td>
<td>AKI Crea=1.2 mg/dL</td>
<td>Interfering RAAS system medication</td>
<td>Possibly</td>
<td>9.6</td>
<td>Death</td>
</tr>
<tr>
<td>Mizzi et al. [291] 2009</td>
<td>Case 1: 53 years, M</td>
<td>Cardiac arrest</td>
<td>NS</td>
<td>Metformin 850 mg TID</td>
<td>Chronic lung disease insulin, amlopidine 10 mg/day, aspirin 100 mg/day,</td>
<td>NS</td>
<td>?</td>
<td>30</td>
<td>Death</td>
<td></td>
</tr>
<tr>
<td>Jung et al. [292] 2009</td>
<td>Case 1: 51 years, M</td>
<td>Progressive dysarthria and the new onset of gait disturbance and myoclonus</td>
<td>UTR</td>
<td>850 mgx2/day for the last 3 months</td>
<td>Chronic lung disease insulin, amlopidine 10 mg/day, aspirin 100 mg/day,</td>
<td>ESRD</td>
<td>-</td>
<td>Most likely</td>
<td>Not reported</td>
<td>Improvement of encephalopathy after metformin was stopped</td>
</tr>
<tr>
<td>Author &amp; year</td>
<td>No. of reported cases</td>
<td>Manifestations</td>
<td>Cause of metformin overload</td>
<td>Dose/serum level of metformin (mcg/mL)</td>
<td>Relevant comorbidities and medication Other medication</td>
<td>Renal function</td>
<td>Cause of AKI (if applicable)</td>
<td>Casual relationship?</td>
<td>Lactate level (mmol/l)</td>
<td>Outcome</td>
</tr>
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<tr>
<td>Van der Linden et al. [293] 2007</td>
<td>1, 85 years, F</td>
<td>NS</td>
<td>Multiple conditions</td>
<td>Normal crea, but eGFR=23 mL/min/1,73 m²</td>
<td>? (Probably not)</td>
<td>Not reported</td>
<td>Death from post-op complications (initially, bowel ischaemia was suspected)</td>
<td>15</td>
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<tr>
<td>Di Grande et al. [294] 2008</td>
<td>1, NS</td>
<td>Malaise and severe weakness tachypnea (Kussmaul’s respiration), agitated and confused, Glasgow Coma Scale score of 13/15, HR = 75 b/min and BP = 110/80 mmHg</td>
<td>?</td>
<td>NS</td>
<td>AKI (crea=9.75 mg/dL)</td>
<td>History of dehydration due to diarrhea</td>
<td>Maybe</td>
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<tr>
<td>Ortega et al. [295] 2007</td>
<td>Case 1: F, 58 years Case 2: M, 68 years Case 3: F, 74 years Case 4: M, 77 years Case 5: F, 61 years Case 6: transferred from another hospital for AKI</td>
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<tr>
<td>Gudmundsdottir et al. [296] 2006</td>
<td>5</td>
<td>Malaise, respiratory distress, myalgia, desorientation, abdominal discomfort, increasing somnolence.</td>
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<tr>
<td>Alvianis et al. [297] 2006</td>
<td>1, 70 years, M</td>
<td></td>
<td>UTR</td>
<td>850 mg TID metformin</td>
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</tbody>
</table>

### Notes
- **NS**: Not stated.
- **UTR**: Unknown time relation.
- **AKI**: Acute Kidney Injury.
- **CHF**: Congestive Heart Failure.
- **CKD**: Chronic Kidney Disease.
- **CHD**: Coronary Artery Disease.
- **RAAS**: Renin-Angiotensin-Aldosterone System.
- **ACEIs/ARBs**: Angiotensin Converting Enzyme Inhibitors/ Angiotensin Receptor Blockers.
- **NSAIDs**: Nonsteroidal Anti-Inflammatory Drugs.
- **LA**: Low Anticoagulant.

### Additional Information
- **Lactate level (mmol/l)**: Indicates the lactate levels reported in each case.
- **Outcome**: Summarizes the outcomes for each case, including death or survival.

---

*Data compiled and formatted by [My Script](http://example.com)*
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Age</th>
<th>Gender</th>
<th>Symptoms</th>
<th>Treatments</th>
<th>Complications</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Von Mach et al.</td>
<td>2004</td>
<td>64</td>
<td>F</td>
<td>Cardiac arrest</td>
<td>NS</td>
<td>?</td>
<td>17.5</td>
</tr>
<tr>
<td>Pertek et al.</td>
<td>2003</td>
<td>65</td>
<td>F</td>
<td>Acute abdominal pain, 48 h of anuria, vomiting, tachypnea</td>
<td>UTR; 850 mg × 3/day</td>
<td>HTN, chronic anemia, gout, Diuretics + NSA + colchicine (26 g in 10 days) + B12 intravenous</td>
<td>Probably 12.4</td>
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<tr>
<td>Berner et al.</td>
<td>2002</td>
<td>83</td>
<td>M</td>
<td>Impaired consciousness, Kussmaul breathing, hypothermia 32.1°C, hemodynamic instability</td>
<td>NS, just high metformin SL</td>
<td>Mild CKD</td>
<td>?</td>
</tr>
<tr>
<td>Barrueto et al.</td>
<td>2002</td>
<td>58</td>
<td>M</td>
<td>Lethargy, hypotension, bradycardia, Suicide attempt</td>
<td>Metformin 20 g ingested; SL = 110</td>
<td>HTN, bipolar disease, CKD20 tablets of 240 mg/tablet of diliazem</td>
<td>Probably 22.8</td>
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<tr>
<td>Reeker et al.</td>
<td>2000</td>
<td>62</td>
<td>F</td>
<td>Found unconscious on her bed, resuscitated several times in the ambulance; fixed dilated pupils, haemodynamically unstable; hypothermia 28°C</td>
<td>UTR; NS</td>
<td>CHD, HF, mild CKD</td>
<td>-</td>
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<tr>
<td>Houwerzijl et al.</td>
<td>2000</td>
<td>52</td>
<td>F</td>
<td>Haematemesis, abdominal complaints and dyspnea</td>
<td>NS</td>
<td>Chronic alcoholism, liver function disorders</td>
<td>?</td>
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<tr>
<td>Doorenbos et al.</td>
<td>2001</td>
<td>66</td>
<td>F</td>
<td>Somnolent, BP = 105 ± 80 mmHg, HR = 100 bpm, abdominal pain</td>
<td>UTR; 850 mg × 3/day for the past 7 months; SL = 19.4 mg/dl</td>
<td>HTN, CKD (baseline creat = 236 micromol/l Insulin, ACE-I)</td>
<td>AKI (crea = 640 micromol/l)</td>
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<tr>
<td>Jain et al.</td>
<td>2001</td>
<td>47</td>
<td>M</td>
<td>A 2-day history of severe headache and transient loss of consciousness on the previous day</td>
<td>UTR; 500 mg × 2/day for the past 3 years</td>
<td>Acute subarachnoid haemorrhage Glyburide 5 mg/day</td>
<td>AKI (crea = 0.25 mmol/l)</td>
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<tr>
<td>Keuse et al.</td>
<td>2001</td>
<td>76</td>
<td>F</td>
<td>Nausea, anorexia, vague abdominal pain, and malaise</td>
<td>UTR; 850 mg × 2/day for the past 3 years; SL = 31.5</td>
<td>HTN, CKD (baseline creat = 2.6 mg/dl), coronary artery bypass surgery after myocardial infarction, Helicobacter pylori infection Diltiazem, clonidine, oral nitroglycerine, lansoprazole, amoxicillin, clarithromycin</td>
<td>AKI (crea = 7 mg/dl)</td>
</tr>
<tr>
<td>Author &amp; year</td>
<td>No. of reported cases</td>
<td>Manifestations</td>
<td>Cause of metformin overload</td>
<td>Dose/serum level of metformin (mcg/mL)</td>
<td>Relevant comorbidities and medication</td>
<td>Other medication</td>
<td>Renal function</td>
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<tr>
<td>Schmidt et al. [306] 2005</td>
<td>1, 75 years, F</td>
<td>A 7-day history of increasing upper abdominal pain, nausea, anorexia and mental confusion, and 2 days of anuria.</td>
<td>UTR</td>
<td>1 g×3/day</td>
<td>Gall stone disease, HTN, acute abscess formation from perforated gall bladder, oral diclofenac 500 mg×3/day for 5 days + rectal diclofenac</td>
<td>Previous normal renal function; AKI (crea=980 micromol/l)</td>
<td>Renal function-interfering medication</td>
</tr>
<tr>
<td>Schmidt et al. [307] 1997</td>
<td>1, 62 years, F</td>
<td>A 4-day history of nausea, diarrhoea and poor concentration Severe nausea, vomiting, diarrhoea, and vague abdominal pain that started the day prior to his presentation Poor appetite and oliguria for 3 days. lethargy. On arrival, EI V1 M1 en (GCS), BP = 115/ 59 mmHg, HR = 132 b/ min, respiration rate = 16 breaths/ minute, T° 30°C.</td>
<td>UTR</td>
<td>500 mg×2/day started 1 months earlier 500 mg×3/day for the past 8 years</td>
<td>HTN, CAD, PTCA Paroxetine, diltiazem, amitriptyline, cisapride, calcitriol, iron sulfate², calcium carbonate Chronic alcohol intake Baseline crea between 0.9 and 1.2 mg/dl; AKI (crea=2.9 mg/dl)</td>
<td>ESRD (PD)</td>
<td>-</td>
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<tr>
<td>Shenoy et al. [308] 2006</td>
<td>1, 48 years, M</td>
<td>Severe nausea, vomiting, diarrhoea, and vague abdominal pain that started the day prior to his presentation</td>
<td>UTR</td>
<td>500 mg×3/day</td>
<td>Suicide attempt</td>
<td>Unknown baseline renal function. AKI (crea=8.1 mg/dL)</td>
<td>Unknown baseline renal function. AKI (crea=8.1 mg/dL)</td>
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<tr>
<td>Yang et al. [309] 2009</td>
<td>1, 43 years, F</td>
<td>Poor appetite and oliguria for 3 days. lethargy. On arrival, EI V1 M1 en (GCS), BP = 115/ 59 mmHg, HR = 132 b/ min, respiration rate = 16 breaths/ minute, T° 30°C.</td>
<td>Suicide attempt</td>
<td>500 mg×2/day for the past 10 years; now: unknown ingested dose of metformin;</td>
<td>Suicide attempt</td>
<td>500 mg×2/day for the past 10 years; now: unknown ingested dose of metformin;</td>
<td>Suicide attempt</td>
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<td>Althoff et al. [310] 1978</td>
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<tr>
<td>Bjarnason et al. [311] 2006</td>
<td>1, 74 years, M</td>
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<td>Brouwers et al. [312] 2009</td>
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<tr>
<td>Chang et al. [313] 2002</td>
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<td>2 suicide attempts</td>
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<tr>
<td>Chu et al. [314] 2003</td>
<td>1, 75 years, F</td>
<td>Vomiting, diarrhoea, hypothermia, hypotension and transitory sudden blindness</td>
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<tr>
<td>Depont et al. [315] 2007</td>
<td>1, 39 years, F</td>
<td>Suicide attempt</td>
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<tr>
<td>De Palo et al. [316] 2005</td>
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<td>El-Hennawy et al. [317] 2007</td>
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<td>Gan et al. [318] 1992</td>
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<td>Hermann et al. [319] 1981</td>
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<tr>
<td>Jurwisch et al. [320] 1997</td>
<td>1, 67 years, M</td>
<td>A 9-day history of weakness, nausea,</td>
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Figure 2.3. Continued
<table>
<thead>
<tr>
<th>Case 1:</th>
<th>70 years, F</th>
<th>Case 2:</th>
<th>48 years, M</th>
<th>Case 3:</th>
<th>62 years, F</th>
<th>Case 4:</th>
<th>80 years, F</th>
<th>Case 5:</th>
<th>61 years, M</th>
</tr>
</thead>
<tbody>
<tr>
<td>dizziness, and difficulty moving</td>
<td>Case 1: collapse and coma</td>
<td>Case 2: scrotal abscess</td>
<td>Case 3: septic shock</td>
<td>Case 4: Vigil coma + AKI (renal + ureteral lithiasis on unique kidney)</td>
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<tr>
<td>Case 1: collapse and coma</td>
<td>Case 2: UTR</td>
<td>Case 3: UTR</td>
<td>Case 4: UTR</td>
<td>Case 5: UTR</td>
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<tr>
<td>Case 1: 1700 mg/day</td>
<td>Case 1: 5100 mg/day + glibornuride</td>
<td>Case 1: 3400 mg/day + glibenclamide</td>
<td>Case 1: 2550 mg/day + gliclazide</td>
<td>Case 1: 1700 mg/day</td>
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<td>Case 1: NS</td>
<td>Case 2: NS</td>
<td>Case 3: NS</td>
<td>Case 4: NS</td>
<td>Case 5: NS</td>
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<td>Case 1: serum crea = 600 micromoll/L at admission</td>
<td>Case 1: NS</td>
<td>Case 2: NS</td>
<td>Case 3: NS</td>
<td>Case 4: NS</td>
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<td>Case 1: AKI - dehydration (vomiting + diarrhoea)</td>
<td>Case 1: UTR</td>
<td>Case 2: UTR</td>
<td>Case 3: UTR</td>
<td>Case 4: UTR</td>
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<td>Case 1: yes</td>
<td>Case 2: yes</td>
<td>Case 3: yes</td>
<td>Case 4: yes</td>
<td>Case 5: yes</td>
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<td>Case 1: 18.4</td>
<td>Case 2: 20.7</td>
<td>Case 3: 12.7</td>
<td>Case 4: 8.3</td>
<td>Case 5: 7.85</td>
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<tr>
<td>Case 1: survived</td>
<td>Case 2: survived</td>
<td>Case 3: survived</td>
<td>Case 4: survived</td>
<td>Case 5: survived</td>
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</tbody>
</table>

Løvås et al. [321] 1987


Survived

Mirouze et al. [341] 1976

1, 72 years, F

Case 1: 70 years, F
Case 2: 48 years, M
Case 3: 62 years, F
Case 4: 80 years, F
Case 5: 61 years, M

All of the cases had either hypovolaemia induced by vomiting or diarrhoea + continuation of renal function-interfering medication

Løvås et al. [341] 2000

1, 79 years, F

Case 1: 76 years, F
Case 2: 73 years, M
Case 3: 63 years, F
Case 4: 77 years, F
Case 5: 73 years, M
Case 6: 83 years, F
Case 7: 55 years, M
Case 8: 70 years, F
Case 9: 57 years, M
Case 10: 58 years, F

Case 1: General malaise, APACHE II score = 35
Case 2: Vomiting, confusion, APACHE II score = 33
Case 3: Diarrhoea, vomiting, cardiac arrest, APACHE II score = 44
Case 4: Diarrhoea, vomiting, malaise, APACHE II score = 33
Case 5: Diarrhoea, lethargy, APACHE II score = 21
Case 6: Vomiting, abdominal pain, APACHE II score = 32
Case 7: -
Case 8: ACEIs, NSAIDs
Case 9: -
Case 10: NSAID

All of the cases had either hypovolaemia induced by vomiting or diarrhoea + continuation of renal function-interfering medication

Continued
<table>
<thead>
<tr>
<th>Author &amp; year</th>
<th>No. of reported cases</th>
<th>Manifestations</th>
<th>Cause of metformin overload</th>
<th>Dose/serum level of metformin (mcg/mL)</th>
<th>Relevant comorbidities and medication</th>
<th>Other medication</th>
<th>Renal function</th>
<th>Cause of AKI (if applicable)</th>
<th>Casual relationship?</th>
<th>Lactate level (mmol/L)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offerhaus et al. [322] 2007 Lalau et al. [323] 1984</td>
<td>1, 85 years, F</td>
<td>Case 1: Vomiting, urinary infection, fever, haematemesis</td>
<td>Case 1: NS</td>
<td>Case 1: 1700mg/day</td>
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<td>Case 1: admission crea = NS; discharge crea = 316 µmol / L</td>
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<td>Case 1: moderate AKI at admission (infection + dehydration)</td>
<td>Case 1: yes</td>
<td>Case 1: 18.42</td>
<td>Case 1: survived</td>
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<td>Case 5: admission crea = NS; discharge</td>
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<td>Case 6: admission crea = 151 µmol / L; discharge crea = 139 µmol / L</td>
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<td>Case 7: admission crea = 91 µmol / L; discharge crea = 76 µmol / L</td>
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<td>Case 8: admission crea = 74 µmol / L; discharge crea = 154 µmol / L</td>
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<td>Case 9: admission crea = 87 µmol / L; discharge crea = 144 µmol / L</td>
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<td>Case 10: admission crea = 77 µmol / L; discharge crea = 55 µmol / L</td>
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<td>Case 1: serum crea = 130 micromoll/L</td>
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</tbody>
</table>

F, female; M=male; NS, not stated; LA=lactic acidosis; MALA, metformin-associated lactic acidosis; LA= lactic acidosis; BP, blood pressure; HR,= heart rate; CAD, coronary artery disease; CHF, chronic heart failure; HTN, hypertension; CHD, coronary heart disease; TID, total ingested dose; CKD, chronic kidney disease; ESRD, end-stage renal disease; PD, peritoneal dialysis; AKI, acute kidney injury; UTR, usual treatment regimen; CIN, contrast-induced nephropathy; therapeutic metformin serum level = 1–2 microg/mL.

Studies in bold are published in non-English language.
### Chapter 3: Issues Related to Management of Cardiovascular Risk in Patients with Diabetes and CKD Stage 3B or Higher (eGFR <45 mL/min)

#### Chapter 3.1

In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) and CAD, is PCI or CABG or conservative treatment to be preferred?

<table>
<thead>
<tr>
<th>Study</th>
<th>Title</th>
<th>Design</th>
<th>Summary conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aoki et al. [324] 2002</td>
<td>Coronary revascularization improves long-term prognosis in diabetic and nondiabetic end-stage renal disease</td>
<td>Cohort study, 121 patients, CABG versus PCI, Diabetes versus nondiabetes</td>
<td>Complete revascularization improves long-term survival in both diabetic and nondiabetic patients. PTCA and CABG posed little risk for renal allograft loss.</td>
</tr>
<tr>
<td>Ferguson et al. [325] 1999</td>
<td>Outcome After Myocardial Revascularization and Renal Transplantation</td>
<td>Cohort study, 83 transplant patients, CABG versus PCI</td>
<td></td>
</tr>
<tr>
<td>Sedlis et al. [326] 2009</td>
<td>OMT with or without PCI for patients with stable CAD and CKD</td>
<td>Post hoc analysis of the COURAGE study; 2287 patients, stable CAD patients with and without CKD randomized to PCI and OMT or OMT alone</td>
<td>PCI did not reduce the risk of death or myocardial infarction when added to OMT for patients with CKD, it also was not associated with worse outcomes in this high-risk group. At 1-year follow-up, mortality rates in the conservative group were significantly higher than in the invasive groups except for the severe CKD group. The benefit of the EI over the DI strategy, although there were no significant differences between the two groups, tended to decrease as renal function decreased. Dialysis patients in the United States had better long-term survival after CABG surgery than after PCI. Stent outcomes were relatively worse in diabetic patients (CABG 19% survival advantage versus PTCA only).</td>
</tr>
<tr>
<td>Hachinohe et al. [144] 2011</td>
<td>Management of non-ST segment elevation acute myocardial infarction in patients with CKD (from the Korea Acute Myocardial Infarction Registry)</td>
<td>Registry Korean Study: 5185 patients in total, EI, DI, and conservative strategies in patients with acute NSTEMI and CKD</td>
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<tr>
<td>Herzog et al. [145] 2002</td>
<td>Comparative survival of dialysis patients in the United States after coronary angioplasty, coronary artery stenting, and coronary artery bypass surgery and impact of diabetes</td>
<td>Registry data to compare the long-term survival of dialysis patients in the United States after PTCA, coronary stenting, or CABG</td>
<td></td>
</tr>
<tr>
<td>Chang et al. [146] 2012</td>
<td>Multivessel CABG versus PCI in ESRD</td>
<td>CABG versus PCI; US Registry data; cohort of 21,981 patients on maintenance dialysis</td>
<td>CABG compared with PCI associated with significantly lower risks for both death (HR = 0.87, 95% CI 0.84–0.90) and the composite of death or myocardial infarction (HR = 0.88, 95% CI 0.86–0.91). We found no evidence that age, race, diabetes, duration of ESRD, MI on index presentation, dialysis modality, stent era, or index year significantly modified the association of CABG and PCI on death.</td>
</tr>
<tr>
<td>Farkouh et al. [327] 2012</td>
<td>Strategies for Multivessel Revascularization in Patients with Diabetes</td>
<td>Randomized trial, patients with diabetes and multivessel coronary artery disease to undergo either PCI with drug-eluting stents or CABG, 1900 patients</td>
<td>For patients with diabetes and advanced CAD, CABG was superior to PCI in that it significantly reduced rates of death and myocardial infarction, with a higher rate of stroke. Subgroup analysis of 129 patients, no difference between CABG versus PCI.</td>
</tr>
</tbody>
</table>
Chapter 3.2. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²) and with a cardial indication (heart failure, ischaemic heart disease, hypertension), should we prescribe inhibitors of the RAAS system or aldosteron-antagonists as cardiovascular prevention? Baseline data of included studies

<table>
<thead>
<tr>
<th>Trial</th>
<th>Intervention</th>
<th>Control group</th>
<th>Study duration (weeks)</th>
<th>Total no of patients</th>
<th>Mean age (years)</th>
<th>Men (%)</th>
<th>Baseline renal function – intervention group</th>
<th>Type of DM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fogari et al. [328] 1999</td>
<td>Ramiprill</td>
<td>Nitrendipine</td>
<td>96</td>
<td>107</td>
<td>58 ± 1</td>
<td>100</td>
<td>Serum creatinine (mg/dL): 2.0 ± 0.4; CrCl (mL/min/1.73 m²): 44.4 ± 8; UAE (g/24 h): 0.79 ± 0.04</td>
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<tr>
<td>Lewis et al. [150] 2001 (IDNT)</td>
<td>Irbesartan</td>
<td>Placebo; Amlodipine</td>
<td>124.8</td>
<td>1715</td>
<td>59.3 ± 7.1</td>
<td>66.4</td>
<td>Serum creatinine (mg/dL): -</td>
<td>-</td>
</tr>
<tr>
<td>Brenner et al. [157] 2001 (RENAAL)</td>
<td>Losartan</td>
<td>Placebo</td>
<td>163.2</td>
<td>1513</td>
<td>60 ± 7</td>
<td>63.1</td>
<td>UPE (g/24 h): 2.9 (iqr 1.6 to 5.4) Serum creatinine (mg/dL): 1.9 ± 0.5</td>
<td>-</td>
</tr>
<tr>
<td>Suzuki et al. [329] 2002</td>
<td>Benazepril</td>
<td>Placebo</td>
<td>48</td>
<td>72</td>
<td>NS</td>
<td>38.8</td>
<td>UPE (g/24 h): 1.2 ± 0.6 Serum creatinine (mg/dL): 3.07 ± 0.5; CrCl (mL/min/1.73 m²): 34.8 ± 9.8; UAE (g/24 h): 1.52 (iqr 0.19 to 4.6) eGFR (mL/min/1.73 m²): 53.65 ± 7.70; UPE (g/24 h): 1.80 (iqr 0.8 to 3.6)</td>
<td>-</td>
</tr>
<tr>
<td>Tong et al. [155] 2006</td>
<td>Fosinopril</td>
<td>Placebo</td>
<td>73.7</td>
<td>38</td>
<td>65 ± 6</td>
<td>65.7</td>
<td>Serum creatinine (mg/dL): -</td>
<td>-</td>
</tr>
<tr>
<td>Guo et al. [330] 2009</td>
<td>Losartan</td>
<td>Amlodipine</td>
<td>24</td>
<td>41</td>
<td>59.2 ± 7.0</td>
<td>43.9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Heerspink et al. [331] 2010 (ADVANCE)</td>
<td>Perindopril-Indapamide</td>
<td>Placebo</td>
<td>206.4</td>
<td>2033</td>
<td>68.3 ± 6.4</td>
<td>42.5</td>
<td>Serum creatinine (mg/dL): 1.9 ± 0.5</td>
<td>-</td>
</tr>
<tr>
<td>Shahinfar et al. [332] 2002 (RENAAL)</td>
<td>Losartan</td>
<td>Placebo</td>
<td>163.2</td>
<td>1513</td>
<td>60 ± 7</td>
<td>63.1</td>
<td>Serum creatinine (mg/dL): -</td>
<td>-</td>
</tr>
<tr>
<td>Berl et al. [333] 2003 (IDNT)</td>
<td>Irbesartan</td>
<td>Placebo; Amlodipine</td>
<td>124.8</td>
<td>1715</td>
<td>59.3 ± 7.1</td>
<td>66.4</td>
<td>Serum creatinine (mg/dL): 1.67 ± 5.4; UPE (g/24 h): 2.9 (iqr 1.6 to 5.4) eGFR (mL/min/1.73 m²): 49.2 ± 9.0</td>
<td>-</td>
</tr>
<tr>
<td>Rahman et al. [153] 2005 (ALLHAT)</td>
<td>Lisinopril</td>
<td>Chlorthalidone; Amlodipine</td>
<td>288</td>
<td>1888</td>
<td>70.6 ± 7.9</td>
<td>NS</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Saruta et al. [334] 2009 (CASE-I)</td>
<td>Candesartan</td>
<td>Amlodipine</td>
<td>153.6</td>
<td>2390</td>
<td>65.6 ± 10.3</td>
<td>51.7</td>
<td>NS</td>
<td>-</td>
</tr>
</tbody>
</table>
## Summary of findings table

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Trials reporting &gt;1 event/total no of trials included</th>
<th>No of patients included</th>
<th>Median treatment duration (weeks)</th>
<th>Relative effect</th>
<th>95% CI</th>
<th>Quality of evidence*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All-cause mortality (overall)</td>
<td>3/4</td>
<td>5309</td>
<td>135.6</td>
<td>0.97</td>
<td>0.85 to 1.10</td>
<td>moderate</td>
</tr>
<tr>
<td>2. CV mortality (only patients with diabetes)</td>
<td>2/2</td>
<td>3748</td>
<td>165.6</td>
<td>1.03</td>
<td>0.75 to 1.41</td>
<td>low</td>
</tr>
<tr>
<td>3. Non-fatal CV events (overall)</td>
<td>3/3</td>
<td>138</td>
<td>161.6</td>
<td>0.90</td>
<td>0.81 to 1.00</td>
<td>low</td>
</tr>
<tr>
<td>4. Need for RRT/doubling of serum creatinine (overall)</td>
<td>3/5</td>
<td>5202</td>
<td>139.5</td>
<td>0.81</td>
<td>0.70 to 0.92</td>
<td>moderate</td>
</tr>
<tr>
<td>5. eGFR/CrCl (mL/min/1.73 m²) –end of treatment (overall)</td>
<td>4/4</td>
<td>2074</td>
<td>120.4</td>
<td>−0.09</td>
<td>−2.75 to 2.57</td>
<td>very low</td>
</tr>
<tr>
<td>6. Total no of reported adverse events (overall)</td>
<td>2/2</td>
<td>1822</td>
<td>110.4</td>
<td>1.05</td>
<td>0.89 to 1.25</td>
<td>low</td>
</tr>
</tbody>
</table>
### Chapter 3.3
In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we prescribe beta blockers to prevent sudden cardiac death?

<table>
<thead>
<tr>
<th>Study</th>
<th>Publication year</th>
<th>Design</th>
<th>Inclusion criteria</th>
<th>Patient characteristics</th>
<th>Intervention (n)</th>
<th>Comparator (n)</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Castagno et al. [172]</td>
<td>2010</td>
<td>RCT</td>
<td>Global</td>
<td>Aged 18–80 years with a left-ventricular ejection fraction of 35% or less. Symptoms had to include dyspnoea on exertion, orthopnoea, or paroxysmal nocturnal dyspnoea, with or without oedema, and fatigue, corresponding to class III or IV of the New York Heart Association. -Uncontrolled hypertension, myocardial infarction or unstable angina pectoris in the previous 3 months, percutaneous transluminal coronary angioplasty or coronary-artery bypass graft in the previous 6 months, previous or scheduled heart transplant, atrioventricular block greater than first degree without a chronically implanted pacemaker, resting heart rate of less than 60 beats per min, SBP at rest of less than 100 mm Hg, renal failure (serum creatinine &gt;300 μmol/L), reversible obstructive lung disease.</td>
<td>Age: 61 -Diabetes: 49.5% -Gender: 80% male -Mean diabetes vintage: 11 years -Kidney function (eGFR): 64.5 mL/min</td>
<td>Bisoprolol 1.25 mg, 2.5 mg, 3.75 mg, 5.0 mg, 7.5 mg, and 10.0 mg/day (n = 1327) -Standard care plus placebo (n = 1320)</td>
<td>All-cause hospital admission -Myocardial infarction -All-cause mortality -sudden death</td>
<td>-HR 0.8 (0.71–0.91, P = 0.006) -HR 0.85 (0.31–2.34, P = 0.75) -HR 0.66 (0.34–0.81, P = 0.0001) -HR 0.56 (0.39–0.80, P = 0.0011)</td>
<td>Low risk of bias RCT</td>
<td>Patients with baseline renal function slightly better than guideline inclusion criteria</td>
</tr>
<tr>
<td>El-Menyar et al. [174]</td>
<td>2010</td>
<td>Prospective cohort study</td>
<td>Middle-East -2007</td>
<td>Consecutive patients with ACS were recruited</td>
<td>Age: 61 to 11 y -Diabetes: 50% -Gender: 64% male -Mean diabetes vintage: 11 years -Kidney function (eGFR): 30–59 mL/min -STEMI: 37%</td>
<td>Registry data on 6518 consecutive patients with ACS, prognostic value of renal function and medication use at discharge -1304 patients with eGFR 30-59 mL/min</td>
<td>-Use of beta blockers decreased as renal function worsened, particularly in patients with STEMI (mild CRI, 64%; moderate CRI, 51%; severe CRI, 43%)</td>
<td>Data collected from an observational study and presented in a descriptive way</td>
<td>The study was unable to determine whether the patient had acute renal dysfunction, chronic, or a combination of both</td>
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<tr>
<td>Erdmann et al. [173]</td>
<td>2001</td>
<td>Europe-NR</td>
<td>Post hoc analyses of the CIBIS II trial (RCT)</td>
<td>Symptomatic ambulatory patients in NYHA class III or IV, with an ejection fraction of ~35%, stable on standard treatment with ACE-inhibitors and diuretics</td>
<td>Age: 61</td>
<td>Bisoprolol 1.25 mg, 2.5 mg, 3.75 mg, 5.0 mg, 7.5 mg, and 10.0 mg/day ($n = 1327$)</td>
<td>All-cause mortality (subgroup analysis on diabetes patients)</td>
<td>-RR 0.81 (95% CI 0.51–1.28)</td>
<td>Funding source bias: “sponsored by E Merck, Darmstadt”</td>
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<td>-Age: 80% male</td>
<td>Renal function: 33% with creatinine clearance &lt;60 mL/min</td>
<td>Standard care plus placebo ($n = 1320$)</td>
<td>-1.3 years</td>
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<td>$n = 1327$</td>
<td>$n = 1327$</td>
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<td></td>
<td>Post hoc and subgroup analysis for data available on patients with diabetes and advanced kidney disease</td>
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<td>-Gender: 80% male</td>
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<td>-Renal function: 33% with creatinine clearance &lt;60 mL/min</td>
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<td>-Age: 61</td>
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<td>All-cause mortality (subgroup analysis on diabetes patients)</td>
<td>-RR 0.81 (95% CI 0.51–1.28)</td>
<td>Funding source bias: “sponsored by E Merck, Darmstadt”</td>
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<td></td>
<td>-Gender: 80% male</td>
<td>Renal function: 33% with creatinine clearance &lt;60 mL/min</td>
<td>Standard care plus placebo ($n = 1320$)</td>
<td>-1.3 years</td>
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<tr>
<td>Gansevoort et al. [335]</td>
<td>1995</td>
<td>Europe-till 1994</td>
<td>Systematic review</td>
<td>Antiproteinuric effect of blood pressure-lowering agents: a meta-analysis of comparative trials</td>
<td>Included were 41 studies, comprising 1124 patients, of which 558 had non-diabetic renal disease</td>
<td>Efficacy to lower proteinuria</td>
<td>-MD -39.9% ($−42.8%$ to $−36.8%$)</td>
<td>No separate subgroup analysis of patients with advanced CKD provided</td>
<td>Mean values of kidney function 82.9 mL/min eGFR.</td>
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<td>-Excluded were reviews, case reports, abstracts, retrospective studies, studies in duration less than 1 week, studies reporting on follow-up of patients described in previous publications, and studies performed in patients with heart failure, renal transplantation or renovascular hypertension</td>
<td>10 studies were on beta blockers with 162 patients included</td>
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<td>-Intervention: -ACE-Is</td>
<td>Comparator-beta blockers</td>
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<td>-Comparator-beta blockers</td>
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<tr>
<td>Knight et al. [171]</td>
<td>1999</td>
<td>Global-1986–1989</td>
<td>RCT</td>
<td>An ejection fraction of &lt;35%</td>
<td>-Age: 59 years</td>
<td>-Diabetes: 19%</td>
<td>-Gender: 86% male</td>
<td>-Kidney function (serum creatinine): 1.3 mg/dL</td>
<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<td>-Exclusion criteria included myocardial infarction within 30 days, arrhythmia-related syncope, major cardiac surgery, unstable angina, uncontrollable hypertension, advanced pulmonary disease, major neurologic disease or cerebrovascular disease, suspected renal artery stenosis, renal failure, other life-threatening disease, and likely non-compliance (eg, alcoholism, drug addiction)</td>
<td>-Diabetes: 19%</td>
<td>-Gender: 86% male</td>
<td>-Kidney function (serum creatinine): 1.3 mg/dL</td>
<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<td>-Included were 41 studies, comprising 1124 patients, of which 558 had non-diabetic renal disease</td>
<td>10 studies were on beta blockers with 162 patients included</td>
<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<td>-Intervention: -ACE-Is, enalapril $n = 3269$</td>
<td>Comparator-placebo, $n = 3246$</td>
<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<td>-Comparator-placebo, $n = 3246$</td>
<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<td>$n = 3246$</td>
<td>$n = 3246$</td>
<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<td>Co-intervention</td>
<td>Beta blockers, 17% from the placebo group and 18% from the intervention group had beta blockers therapy</td>
<td>-974 days</td>
<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<td>Beta blockers, 17% from the placebo group and 18% from the intervention group had beta blockers therapy</td>
<td>-974 days</td>
<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<td>-974 days</td>
<td>-Progression to end-stage kidney disease</td>
<td>-RR 0.70 (0.57–0.85) in both groups when adjusted for the use of beta blockers</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Inclusion criteria</td>
<td>Patient characteristics</td>
<td>Intervention (n)</td>
<td>Comparator (n)</td>
<td>Outcome(s)</td>
<td>Results</td>
<td>Quality of evidence</td>
<td>Notes</td>
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<tr>
<td>Pun et al. [176]</td>
<td>Retrospective case-control study</td>
<td>- Events were included when any of the following key events were described in the database: deployment of an automated external defibrillator (AED), initiation of cardiopulmonary resuscitation, documentation of sudden pulselessness, lack of respiratory difficulties before the event, or a determination of CA after emergency medical services personnel arrived on the scene. - Patients with missing outcome data (n = 15), as well as patients with documented “do not resuscitate” orders (n = 53)</td>
<td>- Age: 68 (13.5) y - Diabetes: 41% - Gender: 49% male - Kidney function (serum creatinine): 6.9 mg/dL - Years on dialysis: 2.3</td>
<td>- Intervention: beta blockers, n = 302 - Comparator: beta blockers not prescribed, n = 373</td>
<td>Odds ratio of death at 6 months according to prescribed medication dosage (low, medium, high) versus not prescribed</td>
<td>OR 0.34 (0.18 to 0.66) - OR 0.25 (0.13 to 0.48) - OR 0.15 (0.07 to 0.29)</td>
<td>No analysis available on diabetes patients, bias by indication</td>
<td>Significantly higher proportion of nonsurvivors had indwelling catheters at the time of the event compared with 6-mo survivors</td>
<td></td>
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<tr>
<td>Tonelli et al. [175]</td>
<td>Prospective cohort study</td>
<td>- All patients seen for routine follow-up of CKD during the 4-week study period in 1999 were eligible. - Dialysis dependence or calculated creatinine clearance (Cockcroft-Gault) more than 75 mL/min</td>
<td>- Age: 60.8 (15.7) years - Diabetes: 37.5% - Gender: 61.8% male - Kidney function - Mean creatinine clearance was 30.3 (18) mL/min</td>
<td>- This study catalogued the percentage of patients with and without DM and at various CKD stages (CrCl) who were exposed to CV protective medicine such as statins, ACE and aspirin</td>
<td>Adherence to treatment strategy Adrenergic blockers, acetylsalicylic acid (ASA), ACE-I, and 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors (statins)</td>
<td>- History of diabetes mellitus was not significantly associated with the use of any of these medications</td>
<td>Old retrospective study; Bias by indication</td>
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</tbody>
</table>
Chapter 3.5. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should we prescribe lipid lowering-therapy in primary prevention?

<table>
<thead>
<tr>
<th>Study</th>
<th>-Publication year</th>
<th>Design</th>
<th>-Inclusion criteria</th>
<th>Patient characteristics</th>
<th>-Intervention (n)</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanner et al.</td>
<td>2005</td>
<td>RCT</td>
<td>Subjects with type 2 diabetes mellitus 18 to 80 years of age who had been receiving maintenance HD for less than two years Levels of fasting LDL cholestero less than 80 mg per deciliter (2.1 mmol per litre) or more than 190 mg per deciliter (4.9 mmol per litre), triglyceride levels greater than 1000 mg per deciliter (11.3 mmol per litre); liver function values more than three times the upper limit of normal or equal to those in patients with symptomatic hepatobiliary cholestatic disease; systemic disease unrelated to end-stage renal disease; vascular intervention, congestive heart failure, or myocardial infarction within the three months preceding the period of enrolment; unsuccessful kidney transplantation; and hypertension resistant to therapy</td>
<td>Age 65.7 ± 8.3 gender: 53% DM2: 100% HD: 100% 17.5 ± 8.7 years with diabetes, 8.2 ± 6.9 months on dialysis</td>
<td>Atorvastatin 20 mg daily -4 years -On intervention n = 619 -Control group n = 636</td>
<td>All-cause mortality -Composite outcome/mortality -Sudden death -Stroke -Myocardial infarction</td>
<td>RR 0.93 (0.79–1.08; P = 0.33) RR 0.92 (0.77–1.10; P = 0.37) RR 1.33 (0.90–1.97; P = 0.15) RR 1.33 (0.90–1.97; P = 0.15) RR 0.88 (0.64–1.21; P = 0.42)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upadhyay et al.</td>
<td>2012</td>
<td>Systematic review</td>
<td>Systematic reviews of RCTs (RCTs) in any language with included data about adults and children with CKD of any stage, including patients receiving dialysis and kidney transplantation patients Trials involving dietary supplements, phosphate binders, apheresis, stanols, or sterols. The minimum follow-up was 6 months. Studies had to include 100</td>
<td>Age 50 to 66 years Mean baseline LDL cholesterol level in intervention groups ranged from 2.59 mmol/L (100 mg/dL) to 4.09 mmol/L (158 mg/dL). Follow-up ranged from 6 months to 5 years, and most participants in each trial were men</td>
<td>Intervention: 1 or more lipid-lowering agents (statins, ezetimibe, niacin, colestipol, or cholestyramine) or lifestyle-modification strategies (weight loss, special diet, or exercise) Comparator: no treatment (or placebo) or other lipid-lowering agents</td>
<td>Myocardial infarction Stroke Survival/CV mortality Survival/mortality</td>
<td>RR 0.76 (0.63–0.91) RR 1.16 (0.75–1.78) RR 0.78 (0.68–0.89) RR 0.93 (0.86–1.01)</td>
<td>Limitations: results were obtained from subgroup analysis</td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Study</th>
<th>-Publication year -Time frame -Location</th>
<th>Design -Inclusion criteria -Exclusion criteria</th>
<th>Patient characteristics -Intervention (n) -Comparator (n) -Duration</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tonelli et al. [336]</td>
<td>-2005 -North America</td>
<td>Post hoc analysis of RCTs</td>
<td>or more participants with CKD per group for adults and 25 or more per group for children -Overall analysis of the West of Scotland Coronary Prevention Study (WOSCOPS), Cholesterol and Recurrent Events (CARE), and Long-Term Intervention with Pravastatin in Ischaemic Disease (LIPID) studies -The maximum baseline serum creatinine values for patient in WOSCOPS, CARE, and LIPID were 1.7, 2.5, and 4.5 mg/dL, respectively; patients with creatinine values above these levels were ineligible</td>
<td>-Age 64.2 ± 7.0 years -Male gender 78% -DM2: 100% -MDRD eGFR: 57.9 ± 12.7 mL/min</td>
<td>Intervention pravastatin 40 mg daily, n = 290 -Control: placebo, n = 281 -Intervention duration: ~5 years</td>
<td>Myocardial infarction -Stroke -Survival/mortality-any cause -Survival/mortality: composite outcome: Coronary heart disease death, nonfatal MI, CABG, or PTCA</td>
<td>HR 0.84 (0.6–1.18)</td>
</tr>
<tr>
<td>Ting et al. [337]</td>
<td>-2012 -Australia/New Zealand -1998–2010</td>
<td>RCT</td>
<td>-Type 2 diabetes mellitus with onset after the age of 35 years; men and women aged 50–75 years of age: average total cholesterol 3.0–6.5 mmol/L; triglycerides/high-density cholesterol ratio of 4.0 or higher, or triglycerides over 1.0 mmol/L; -Plasma creatinine &gt;130 mmol/L, liver or symptomatic gallbladder disease, or a cardiovascular event within 3 months before recruitment</td>
<td>-Age 66.51 (5.92) years -Male gender 56% -Diabetes vintage 6.02 (5.55–6.54) years -Kidney function 30–59 mL/min/1.73 m² eGFR</td>
<td>Intervention fenofibrate 200 mg daily, n = 295 -Control: placebo, n = 224 -Co-intervention: diet -Intervention duration: ~5 years</td>
<td>Myocardial infarction -Major CV events -Progression to end-stage kidney disease -Stroke -CV mortality -Survival/all-cause mortality</td>
<td>RR 0.76 (0.68–0.86; P = 0.03)</td>
</tr>
<tr>
<td>Palmer et al. [185]</td>
<td>-2012 -Global -1955–2012</td>
<td>Systematic review</td>
<td>-Randomized trials that compared statins with placebo, no treatment, standard care, or another statin and reported data for adults with CKD (any stage) -Studies with less than 8 weeks of follow-up</td>
<td>48 comparisons included 39 820 persons not receiving dialysis. 21 comparisons included 7982 persons receiving dialysis; 17 comparisons included 3297 kidney transplant recipients</td>
<td>Intervention: statins, most trials (60 comparisons [70%]) evaluated statin doses equivalent to simvastatin, 20 mg, or less -Control: placebo or no treatment -Median follow-up was 6</td>
<td>Myocardial infarction -Stroke -Survival/all-cause mortality -Survival/CV mortality</td>
<td>RR 0.76 (0.62–1.2, P = 0.07)</td>
</tr>
<tr>
<td>Reference</td>
<td>Year</td>
<td>Study Design</td>
<td>Participants</td>
<td>Intervention</td>
<td>Control</td>
<td>Duration</td>
<td>Outcomes</td>
</tr>
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<tr>
<td>Jun et al. [187]</td>
<td>2012</td>
<td>Systematic review</td>
<td>RCTs assessing the effects of fibrate therapy compared with placebo in people with CKD or on kidney-related outcomes</td>
<td>Age between 51 and 67 years</td>
<td>DM2 40%</td>
<td>Male gender ranging from 63% to 100%</td>
<td>-Total number of included patients 51099</td>
</tr>
<tr>
<td>Holdaas et al. [338]</td>
<td>2011</td>
<td>RCT</td>
<td>Diabetes subjects with end-stage renal failure aged 50–80 years, who have received regular HD treatment for at least 3 months</td>
<td>Age 65 (8.2) years</td>
<td>DM2 100%</td>
<td>Male gender 65%</td>
<td>-Age between 51 and 67 years</td>
</tr>
<tr>
<td>Colhoun et al. [339]</td>
<td>2009</td>
<td>RCT</td>
<td>Patients with type 2 diabetes, no previous CVD and at least 1 of the following risk factors: history of hypertension, retinopathy (ie, any retinopathy, maculopathy, or prior photocoagulation), microalbuminuria or macroalbuminuria, or current smoking. Excluded if had history of myocardial infarction, angina, coronary vascular surgery, cerebrovascular</td>
<td>Age 65.0 ± 6.7 years</td>
<td>DM2 100%</td>
<td>Male gender 65%</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Patient characteristics</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baigent et al. [186]</td>
<td>Global RCT</td>
<td>Age 62 (12) years, Male 63%, DM2 23%, Kidney function: MDRD-estimated GFR (mL/min per 1.73 m²): 26.6 (12.9), On dialysis ~33%, HD ~27%, PD ~6%, not on dialysis ~67%</td>
<td>Intervention simvastatin 20 mg plus ezetimibe 10 mg daily, ( n = 4650 )</td>
<td>RR 0.78 (0.64–0.94)</td>
<td>Limitation: primary outcome changed during the study, composite outcome</td>
<td></td>
</tr>
</tbody>
</table>

- Design: RCT
- Exclusion criteria:
  - History of CKD: pre-dialysis or on dialysis, aged greater than or equal to 40 years
  - History of myocardial infarction or coronary revascularization procedure; renal transplant, less than 2 months since presentation as an acute uraemic emergency, history of chronic liver disease, or abnormal liver function
  - Evidence of active inflammatory muscle disease, previous adverse reaction to a statin or to ezetimibe. Concurrent treatment with a contraindicated drug
  - Child-bearing potential, known to be poorly compliant with clinic visits or prescribed medication, history of cancer other than non-melanoma skin cancer, or recent history of alcohol or substance misuse.

- Inclusion criteria:
  - Age 62 (12) years
  - Male 63%
  - DM2 23%
  - Kidney function: MDRD-estimated GFR (mL/min per 1.73 m²): 26.6 (12.9), On dialysis ~33%, HD ~27%, PD ~6%, not on dialysis ~67%

- Intervention (n)
  - Intervention simvastatin 20 mg plus ezetimibe 10 mg daily, \( n = 4650 \)
  - Control: placebo, \( n = 4620 \)

- Duration: 4.0 years

- Outcome(s)
  - Major atherosclerotic events: defined as the combination of non-fatal myocardial infarction, coronary death, ischaemic stroke, or any revascularization procedure (i.e. exclusion of non-coronary cardiac deaths and strokes confirmed to be haemorrhagic)

- Results
  - RR 0.78 (0.64–0.94)
### Chapter 3.6. In patients with diabetes and CKD stage 3b or higher, should we recommend interventions to increase energy expenditure and reduce energy intake?

<table>
<thead>
<tr>
<th>Authors</th>
<th>Design</th>
<th>Inclusion criteria</th>
<th>Patient characteristics</th>
<th>Intervention (n)</th>
<th>Comparator (n)</th>
<th>Duration</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tawney et al. [195]</td>
<td>RCT</td>
<td>HD patients, sufficient mobility to move independently around a room, screened by nephrologists to ensure they were medically stable at the start, excessive fluid gain, severe valvular disease, uncontrolled angina, severe joint pain, dizziness, dyspnoea, uncompensated congestive heart failure, inadequately managed diabetes, uncontrolled hypertension, hyperkalaemia, screened by physician trained in physical medicine and rehabilitation to identify safety concerns as poor balance</td>
<td>Age: 58.1 ± 14, Diabetes: 49.5%, Gender: 40% male, Mean dialysis vintage: 31 months</td>
<td>Individual counselling to exercise 30 min each day (household activities) (n = 51)</td>
<td>Standard care (n = 48)</td>
<td>6 months</td>
<td>QoL, Mental component, QoL, Physical component, Physical functioning score</td>
<td>Patient satisfaction</td>
<td>Low level of baseline participation, Dropouts were excluded from analysis</td>
<td>Mixed group of diabetes and non-diabetes</td>
</tr>
<tr>
<td>Castaneda et al. [191]</td>
<td>RCT</td>
<td>&gt;55 years and type 2 diabetes of at least 3 years duration, Myocardial infarction (within past 6 months), any unstable chronic condition (including dementia, alcoholism, dialysis, retinal haemorrhage or detachment), current participation in resistance training</td>
<td>Mean age: 66, Diabetes type 2: 100%, HbA1c: 8.6%, BMI: 31kg/m², 59.6% affected by CV disease</td>
<td>Progressive resistance training, 45 min 3 times/week (n = 31)</td>
<td>Standard care: two-weekly telephone calls, control visit every 3 months (n = 31)</td>
<td>16 weeks</td>
<td>SBP (mmHg), DBP (mmHg), HbA1c (%), FBG (mmol/L), Body weight (kg), Functional status (on physical activity score questionnaires)</td>
<td>Mean (SE) SBP: 135.5 (3.3) C: 150.4 (3.9) P = 0.05 DBP: 69.2 (1.2) C: 70.8 (1.4) P = 0.52 HbA1c: 7.6 (0.2) C: 8.3 (0.5) P = 0.01 FBG: 7.9 (0.4) C: 8.9 (0.7) P = 0.34 Body weight: 79.5 (3.3) C: 79.4 (2.9) P = 0.89 Functional status: 28.3 (0.9) C: 7.2 (2.8) P = 0.01</td>
<td>Possible allocation bias: higher percentage on insulin in control group</td>
<td>Small groups and medication change during study</td>
</tr>
<tr>
<td>Morales et al. [196]</td>
<td>RCT</td>
<td>Chronic proteinuric nephropathy of diabetic or non-diabetic cause, BMI &gt;27 kg/m², serum creatinine level less than 2 mg/dL, unstable clinical condition, rapid loss of renal function, nephrotic syndrome requiring diuretic therapy, immunosuppressive treatment, hypertension requiring more than 2 drugs</td>
<td>Mean age: 56, Diabetes: 47% type 2, Gender: 60% male, Mean serum creatinine: 1.5 mg/dL</td>
<td>Energy reduction of 500 kcal/day, protein content adjusted to 1 to 1.2 g/kg/day (n = 20)</td>
<td>Standard medical care (n = 10)</td>
<td>5 months</td>
<td>SBP (mmHg), DBP (mmHg), Serum creatinine (mg/dL), Creatinine clearance (Cockroft-Gault formula), Proteinuria (g/24h), Weight (kg), BMI (kg/m²)</td>
<td>Mean (SD) SBP: 138.5 (14.1) C: 140.4 (18.3) DBP: 76.6 (8.8) C: 88.5 (11.1) Creatinine clearance: 1.5 (0.8) C: 1.8 (0.6) P &lt;0.05 Proteinuria: 1.9 (1.4) C: 3.5 (2.1) P &lt;0.05</td>
<td>Sequence generation and allocation concealment unclear</td>
<td>Small groups, combination of diabetes and non-diabetes</td>
</tr>
</tbody>
</table>
### Table 3.6.2

<table>
<thead>
<tr>
<th>Authors</th>
<th>Publication year</th>
<th>Design</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
<th>Patient characteristics</th>
<th>Intervention (n)</th>
<th>Comparator (n)</th>
<th>Duration</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sigal et al. [194]</td>
<td>2007</td>
<td>RCT</td>
<td>- Type 2 diabetes, baseline HbA1c between 6.6% and 9.9%</td>
<td>- Current insulin therapy, participation in exercise 2 or more times weekly for 20 minutes or longer per session or in any resistance training during the previous 6 months, changes during the previous 2 months in oral hypoglycaemic, antihypertensive or lipid-lowering agents or body weight (&gt; or = 5%), serum creatinine level of 200 μmol/L or greater (&gt; or = 2.26 mg/dL), proteinuria greater than 1 g/day, blood pressure greater than 160/95 mmHg, restrictions in physical activity because of disease, presence of other medical condition that made participation advisable</td>
<td>- Mean age: 54 - 100% type 2 diabetes</td>
<td>- Intervention 1: 15 to 20 min per session at 60% of HFmax to 45 min per session at 75% of the HFmax 3 times/week (n = 60)</td>
<td>SBP (mmHg) DBP (mmHg) HbA1c (%) Body weight (kg) BMI (kg/m²) Hospital admissions intervention group (%) Hypoglycaemia intervention group (%)</td>
<td>Compared with AE Mean difference (95% CI)</td>
<td>- Selection bias: only patients with few comorbidities and better functional status were selected</td>
<td>Hospitalizations were elective and not related to intervention; hypoglycaemias were not severe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Leehey et al. [193]

**-** North America  
**RCT**  
- Obese type 2 diabetes patients, CKD stage 2–4 with proteinuria. Treatment with ACE-i or ARB, aspirin and statin if LDL > 100. CKD stages other than 2–4. Hyperparathyroidism/osteoporosis. Symptomatic neuropathy/retinopathy. Positive stress test due to coronary arterial disease. Symptomatic cardiovasc disease. Congestive Heart Failure (NYHA III or IV). COPD (FEV1 <50% and/or requires suppl oxigen support during exercise). Complaints of angina during stress test. Cerebrovascular disease/ cognitive impairment. Renal transplant. Inability to walk on the treadmill. Any unforeseen illness of disability that would preclude exercise testing or training. Participation in a formal exercise program within the previous 12 weeks  
- Mean age: 66  
- Gender: 100% male  
- Aerobic walking exercise, increasing intensity, 30 to 40 min 3 times/week (n = 7)  
- Standard care (n = 4)  
- 24 weeks  

| SBP (mmHg) | Mean (SD) I: 113 (16) C: 136 (5) | 1.3 (−3.4 to 1.7) I: 1.7 P = 0.59 | 3.2 (−1.4 to 7.8) C: 1.7 P = 0.168 | Significant baseline differences between groups |
| DBP (mmHg) | Mean (SD) I: 65 (10) C: 77 (8) | −1.7 (1.5 to 4.9) I: 0.30 P = 0.30 | −1.5 (−0.83 to −0.39) I: 0.46 P = 0.30 | Small group of patients |
| HbA1c (%) | Mean (SD) I: 0.09 P = 0.014 | −0.09 (−3.1 to 1.0) I: 0.15 (−0.09 to 0.09) | −0.23 (−3.1 to 1.0) I: 0.15 (−0.09 to 0.09) |
| Body weight (kg) | Mean (SD) I: 0.98 P = 0.075 | 0.03 (−0.58 to 0.31) I: 0.53 P = 0.93 | −0.50 (−1.05 to 0.04) I: 0.53 P = 0.93 |
| BMI (kg/m²) | Mean (SD) I: 3.0 | 0 | 0.04 P = 0.069 |
| Hypoglycaemia intervention group (%) | | | |
| Hospital admissions intervention group (%) | | | |

### Chen et al. [192]

**-** Asia  
**Quasi-RCT**  
- Stable CKD patients not on dialysis, selected by researcher  
- Exercise advice: 30 min per session, 3 to 4 times a week  

| Mean (SD) | I: 115 (23) C: 136 (20) | 10.2 (2.8) I: 6.6 (2.1) | 8.1 (2.4) I: 8.3 (2.4) | Selection bias, patients were |
| Creatinine clearance (mL/min) | Mean (SD) I: 6.5 (10) C: 77 (8) | I: 51 (26) C: 64 (10) | I: 10.2 (2.8) C: 6.6 (2.1) | |
| HbA1c (%) | Mean (SD) I: 115 (23) C: 136 (20) | | | |
| Mean duration exercise (min) | Mean (SD) I: 115 (23) C: 136 (20) | | | |
| Weight change (kg) | Mean (SD) I: 115 (23) C: 136 (20) | | | |
| Proteinuria (mg/24h) | Mean (SD) I: 115 (23) C: 136 (20) | | | |

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<table>
<thead>
<tr>
<th>Authors</th>
<th>Design</th>
<th>Inclusion criteria</th>
<th>Patient characteristics</th>
<th>Intervention (n)</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MacLaughlin et al. [197]</td>
<td>Non-RCT</td>
<td>CKD patients with BMI &gt; 30 or BMI &gt; 28 kg/m² with comorbidities (diabetes, hypertension, dyslipidaemia), all eligible for kidney transplant, age between 18 and 65. No exclusion criteria mentioned</td>
<td>Mean age: 78 - Diabetes: 41.5% - Gender: 78% male</td>
<td>5 times/week, group sessions and individual guidance over telephone (n = 45) - General health education (n = 49) - 3 months - Individual diet and exercise plan, at least 3 times/week, with increasing time and intensity, Orlistat 3 times 120 mg/day (n = 32) - Standard care (n = 20)</td>
<td>Mean blood glucose (mg/dL)</td>
<td>Mean (SD)</td>
<td>E: 114.81 (30.28) C: 110.31 (25.58)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Matsuoka et al. [199]</td>
<td>Retrospective cohort study</td>
<td>Diabetes mellitus patients with diabetic nephropathy - No exclusion criteria mentioned</td>
<td>Mean age: 49 - Diabetes: 31% (all type 2) - Gender: 61% male</td>
<td>24 months</td>
<td>SBP (mmHg) DBP (mmHg) Decrease in eGFR (MDRD formula) from baseline (mL/min) (only CKD 3–4) Body weight (kg) Accepted on kidney transplant list (%) Number of transplants</td>
<td></td>
<td>Mean (SD)</td>
<td>I: 158 (27) C: 160 (11) E: 86 (9) C: 85 (7) E: 27.7 (13.9) C: 27.4 (14.7) E: 6.0 (3.8) C: 8.6 (4.4) E: 82.7 (4.6) C: 77.1 (4.9) P &lt;0.05</td>
</tr>
<tr>
<td>Cappy et al. [198]</td>
<td>Before-after study</td>
<td>HD patients with stable general and cardiovascular conditions - Any unstable medical condition</td>
<td>Age: 53.9 ± 15 - Diabetes: 50%, type not specified - Gender: 62% male</td>
<td>Training programme consisting in a progressive, self-paced aerobic exercise, 20 to 40 min, 3 times/week (n = 4) - 12 months</td>
<td>SBP predialysis DBP predialysis Serum creatinine Serum glucose level</td>
<td></td>
<td>Mean % of change</td>
<td>-4% -1% 0% -16%</td>
</tr>
<tr>
<td>Solerte et al. [200]</td>
<td>Prospective cohort study</td>
<td>Obese type 1 or 2 diabetic patients with CKD</td>
<td>100% diabetes patients, type not specified</td>
<td>MAP (mmHg) Creatinine clearance Difference in change from baseline</td>
<td>Creatinine clearance change probably explained by less</td>
<td></td>
<td>Creatinine clearance</td>
<td>Small group Diet also improved total cholesterol, LDL</td>
</tr>
</tbody>
</table>
| Saiki et al. [201] | 2005 Prospective cohort study | - Overweight type 1 or 2 diabetic patients with diabetic retinopathy, proteinuria (urinary albumin excretion >300 mg/day) and serum creatinine level less than 3 mg/dL
- Unstable diabetic retinopathy, pleural effusion, severe leg oedema |
| - Age: 53.6 ± 8.4 |
| - BMI 30.4 ± 5.3 kg/m² |
| - 100% diabetes, HbA1c 7.11 ± 1.42 |
| - eGFR 40.6 ± 17.9 mL/min |
| - Proteinuria 3.27 ± 2.63 g/24h |
| n = 24 |
| 52 weeks |
| 740–970 kcal per day diet (n = 22) |
| -7.4 (P < 0.05) |
| - 5.0 (NS) |
| - 5.0 (NS) |
| - 2.2 (P < 0.0001) |
| Changes in creatinine and proteinuria were significantly related to those on BMI (r = 0.62 and 0.49 respectively). |
| Short intervention, very restricted diet. |
### Chapter 3.7. In patients with diabetes and CKD stage 3b or higher (eGFR <45 mL/min/1.73 m²), should antiplatelet therapy be recommended, regardless of their cardiovascular risk?

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Inclusion criteria</th>
<th>Patient characteristics</th>
<th>Intervention (n)</th>
<th>Comparator (n)</th>
<th>Platelet aggregation</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Angiolillo et al. [209] | Case series                   | Type 2 DM patients with stable CAD. Angiographically documented CAD, because they had all previously undergone PCI. Known allergies to aspirin or clopidogrel; type 2 DM without pharmacological treatment; gestational diabetes; dialysis; blood dyscrasia; active bleeding or bleeding diathesis; gastrointestinal bleed within last 6 months; haemodynamic instability; acute coronary or cerebrovascular event within 3 months; any malignancy; concomitant use of other antithrombotic drugs (oral anticoagulants, dipyridamole, cilostazol, ticlopidine) or nonsteroid anti-inflammatory drugs; recent treatment with a glycoprotein IIb/IIIa antagonist; platelet count <100/ 10^6/l; haematocrit <25%; and liver disease (bilirubin level 2 mg/dL) | Age: 72 ± 8  
DM2: 100%  
Gender: 54% Male  
eGFR< 60 mL/min  
HbA1C: 7 ± 1.4 | Aspirin 100 mg/day (n = 84) | -at least 3 months | -Improved platelet aggregation after aspirin treatment | Possible indication bias. Uncontrolled study | DM patients with moderate/severe CKD had significantly higher ADP-induced (60 ± 13% versus 52 ± 15%, P <0.001) and collagen-induced (49 ± 20% versus 41 ± 20%, P = 0.004) platelet aggregation compared with those without |
| Daimon et al. [340]    | Prospective cohort study       | HD patients                                                                         | -Dialysis patients                                           | -Diabetic patients on antiplatelet therapy (aspirin, ticlopidine, clopidogrel, cilostazol, sarpogrelate hydrochloride or warfarin) (n = 21) | -Diabetic patients not receiving antiplatelet | -Bleeding episodes | -13 episodes in patients on antiplatelet therapy versus 3 in those not on antiplatelet therapy (P <0.05)  | Exposed cohort poorly representative (single centre) Not adjusted for the most important confounders (only stratification by diabetes) Primary outcomes addressed | Results poorly reliable: no effect measure provided. Unadjusted analyses |
### Study Designs - Publication year - Time frame - Location

<table>
<thead>
<tr>
<th>Design</th>
<th>Inclusion criteria</th>
<th>Patient characteristics</th>
<th>Intervention (n)</th>
<th>Comparator (n)</th>
<th>Duration</th>
<th>Outcome(s)</th>
<th>Results</th>
<th>Quality of evidence</th>
<th>Notes</th>
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<tr>
<td>Dasgupta et al. [202]</td>
<td>-2009 -2002-2005 -Global (32 centres)</td>
<td>-45 years of age or older and had one of the following conditions: multiple atherothrombotic-risk factors: documented coronary disease, documented cerebrovascular disease, or documented symptomatic peripheral arterial disease -Taking oral antithrombotic medications or nonsteroidal antiinflammatory drugs on a long-term basis (although cyclooxygenase-2 inhibitors were permitted) -Established indications for clopidogrel therapy (such as a recent ACS) -Patients who were scheduled to undergo a revascularization and require clopidogrel after revascularization</td>
<td>-Age: 63 years -Gender: 65% male -DM2: 100% -Co-medications were: diuretics (48.2%) nitrates (23.2%) calcium antagonists (36.7%) beta blockers (55%) angiotensin II receptor blockers (25.5%) ACE-Is (58.6%) statins (76.8%) Insulin (17.4%) oral hypoglycaemic agents (42.3%)</td>
<td>-Clopidogrel (75 mg once daily) plus low-dose aspirin (75 to 162 mg once daily) (n = 1006) -Placebo +low-dose aspirin (75 to 162 mg once daily) (n = 1006)</td>
<td>-30 months</td>
<td>-Severe bleeding -Moderate bleeding -Hospitalization -Overall CV death/MI/stroke/hospitalization -Non-fatal MI -Non-fatal stroke -Overall CV death/MI/stroke -Overall death -Overall CV death</td>
<td>-HR 1.8 (0.90–3.30; P = 0.075) -HR 1.2(0.70–2.00; P = 0.543) -HR 0.9 (0.70–1.20; P = 0.634) -HR 1.0(0.80–1.30; P = 0.784) -HR 0.8(0.40–1.30; P = 0.347) -HR 0.9(0.50–1.70; P = 0.766) -HR 1.1(0.80–1.60; P = 0.405) -HR 1.6 (1.10–2.40; P = 0.008) -HR 1.7 (1.10–2.60; P = 0.023)</td>
<td>Random sequence adequately generated and allocation adequately conceived. Participants and personnel blinded to treatment. Unknown whether outcome assessors were blinded. All established outcomes measures</td>
<td>Post hoc analysis of the CHARISMA RCT in pts with diabetic nephropathy</td>
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<tr>
<td>McCullough et al. [207]</td>
<td>-2002 -1990–1998 -North America</td>
<td>-ST-segment elevation AMI, defined as characteristic chest pain and ST-segment elevation of 1 mm in 2 contiguous leads on the initial electrocardiogram with a consistent rise and fall of the creatinine phosphokinase myocardial</td>
<td>-Age: 63.4 years -Gender: 73% male -Various renal impairment -The combination of ASA + BB was used in 63.9%, 55.8%, 48.2%, and 35.5% of patients with corrected creatinine clearance</td>
<td>-Acetylsalicylic acid (n = 262) -Beta blockers (n = 328) -Acetylsalicylic acid plus beta blockers (n = 902) -No acetylsalicylic acid or beta blockers (n = 232)</td>
<td>Episodes of (in no ASA or BB, ASA alone, BB alone, ASA +BB): -Haemoptoma -Gastrointestinal bleeding -Shock -Sustained hypotension -Asthote -Ventricular fibrillation</td>
<td>-0.4,0,10 (P = NS) -1.1,0,3 (P = 0.82) -58,42,15, 30 (P =0.001) -101,95,83,173 (P =0.001) -21,16,11, 12</td>
<td>Case definition and case representatives adequate. Controls adequately selected from the same population. Controlled by the most important confounders</td>
<td>No data on ASA intolerance or allergy, no doses reported</td>
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</table>
Patients with a new left bundle branch block were included when a history consistent with ischaemic chest pain and a positive CK-MB were present. Chest pain of undetermined origin, unstable angina, non-Q-wave myocardial infarction, and heart failure with and without ischaemic contribution, all diagnoses outside of ST-segment elevation AMI, coma, arrhythmias, and gastrointestinal bleeding.

<table>
<thead>
<tr>
<th>Nakamura et al. [208]</th>
<th>2005</th>
<th>Asia</th>
<th>Quasi-RCT</th>
<th>Patients with diabetic nephropathy (microalbuminuria (20–200 μg/min)) and non-silent cerebral infarction</th>
<th>-Age: 55.5 years</th>
<th>-Dilated dihydrochloride plus standard therapy (including ACEi, ARB, calcium antagonists, beta blockers, alpha blockers), 300 mg/day (n = 15)</th>
<th>-Microalbuminuria</th>
<th>-MD 180 ± 48 versus 64 ± 22 μg/min (P &lt;0.01)</th>
<th>Quasi RCT. Allocation concealment and blinding unclear. Primary outcomes adequately assessed. Unclear if follow-up was completed for all subjects. All expected outcomes measured in all subjects</th>
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<td>-Gender: 70% male</td>
<td>-Standard therapy (including ACEi, ARB, calcium antagonists, beta blockers, alpha blockers)</td>
<td>-Silent cerebral infarction</td>
<td>-Incidence 33.3% versus 6.7% (P &lt;0.01)</td>
<td>Not adjusted for the most important confounders. Not controlled for additional confounders</td>
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<td>-DM2: 100%</td>
<td>-Dilazep didehydrochloride plus standard therapy (including ACEi, ARB, calcium antagonists, beta blockers, alpha blockers), 300 mg/day (n = 15)</td>
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<td>-Diabetes vintage: 12 years (mean)</td>
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<td>-sCr: 79.55 μmol/L</td>
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<td>-HbA1c: 7.8%</td>
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<td>Palmer et al. [204]</td>
<td>2012</td>
<td>1980–2011</td>
<td>Systematic review of RCTs or quasi-RCTs</td>
<td>Any study of adults CKD patients comparing antiplatelet agents with placebo, standard care, or no treatment trials with follow-up longer than 1 year</td>
<td>-31 trials (20942 patients) included</td>
<td>-Antiplatelet therapy (aspirin, dipyridamole, clopidogrel, sulfinpyrazone, ticlopidine, or picotiamide)</td>
<td>-Minor bleeding in persons at risk for or with stable cardiovascular disease (8 RCTs, 7202 pts)</td>
<td>-RR 1.70 (0.44-2.02; P = 0.69)</td>
<td>List of included and excluded studies provided Characteristics of included studies given Scientific quality of studies assessed. Methods to combine findings correct Likelihood of publication bias provided</td>
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<td>-eGFR &lt;60 mL/min</td>
<td>-Placebo</td>
<td>-Major bleeding in persons at risk for or with stable cardiovascular disease (18 RCTs, 10230 pts)</td>
<td>-RR 1.29 (0.69-2.42; P = 0.98)</td>
<td>In all studies analysed, methods for random sequence generation, allocation concealment, blinding of outcome assessors, completeness to follow-up, or the risk for selective reporting or other biases were mostly unclear or inadequate</td>
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<td>-Major bleeding after ACS or PCI (9 RCTs,</td>
<td>-RR 1.40 (1.05-1.86; P = 0.09)</td>
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<td>-RR 1.47 (1.25-1.72; P = 0.001)</td>
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<td>-RR 0.89 (0.76-1.05; P = 0.41)</td>
<td>-RR 0.66 (0.51-1.87; P = 0.87)</td>
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<td>Study</td>
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<td>Patient characteristics</td>
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<td>Minor bleeding after ACS or PCI (9 RCTs, 5776 pts)</td>
<td>- Minor bleeding after ACS or PCI (9 RCTs, 5776 pts)</td>
<td>- Fatal or nonfatal myocardial infarction in patients after ACS or PCI (7 RCTs, 5261 pts)</td>
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<td>RR 0.93 (0.84-1.04; P = 0.84)</td>
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<td>Fatal or nonfatal myocardial infarction in patients after ACS or PCI (7 RCTs, 5261 pts)</td>
<td>- Fatal or nonfatal myocardial infarction in persons at risk for or with stable cardiovascular disease (10 RCTs, 9233 pts)</td>
<td>- Coronary revascularization in patients after ACS or PCI (7 RCTs, 5265 pts)</td>
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<td>RR 0.66 (0.16-2.78; P = 0.22)</td>
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<td>- Fatal or nonfatal myocardial infarction in persons at risk for or with stable cardiovascular disease (10 RCTs, 9233 pts)</td>
<td>- Coronary revascularization in patients after ACS or PCI (7 RCTs, 5265 pts)</td>
<td>- Fatal or nonfatal in persons with CKD at risk for or with stable cardiovascular disease (10 RCTs, 9133 pts)</td>
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<td>RR 1.08 (0.47-2.49; P = 0.45)</td>
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<td>- Fatal or nonfatal in persons with CKD at risk for or with stable cardiovascular disease (10 RCTs, 9133 pts)</td>
<td>- Fatal or nonfatal in persons with CKD at risk for or with stable cardiovascular disease (10 RCTs, 9133 pts)</td>
<td>- Haemorrhagic stroke in patients after ACS or PCI (5 RCTs, 4035 pts)</td>
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<td>RR 0.87 (0.61-1.24; P = 0.68)</td>
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<td>- Haemorrhagic stroke in patients after ACS or PCI (5 RCTs, 4035 pts)</td>
<td>- Haemorrhagic stroke in patients after ACS or PCI (5 RCTs, 4035 pts)</td>
<td>- All-cause mortality in persons at risk for or with stable cardiovascular disease (21 RCTs, 10632 pts)</td>
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<td>RR 0.89 (0.75-1.05; P = 0.48)</td>
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<td>- All-cause mortality in persons at risk for or with stable cardiovascular disease (21 RCTs, 10632 pts)</td>
<td>- All-cause mortality in persons at risk for or with stable cardiovascular disease (21 RCTs, 10632 pts)</td>
<td>- Death due to cardiovascular causes in patients after ACS or PCI (2 RCTs, 411 pts)</td>
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<td>RR 0.96 (0.79-1.16; P = 0.46)</td>
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<td>- Death due to cardiovascular causes in patients after ACS or PCI (2 RCTs, 411 pts)</td>
<td>- Death due to cardiovascular causes in patients after ACS or PCI (2 RCTs, 411 pts)</td>
<td>- Death due to cardiovascular causes in persons with CKD at risk for or with stable cardiovascular disease</td>
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<td>RR 1.08 (0.54-2.16; P = 0.31)</td>
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<td>- Death due to cardiovascular causes in persons with CKD at risk for or with stable cardiovascular disease</td>
<td>- Death due to cardiovascular causes in persons with CKD at risk for or with stable cardiovascular disease</td>
<td>- All-cause mortality in patients after ACS or PCI (8 RCTs, 5260 pts)</td>
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<td>RR 0.91 (0.60-1.36; P = 0.21)</td>
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<td>- All-cause mortality in patients after ACS or PCI (8 RCTs, 5260 pts)</td>
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<td>- Death due to cardiovascular causes in patients after ACS or PCI (2 RCTs, 411 pts)</td>
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<td>RR 0.96 (0.75-1.24; P = 0.48)</td>
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<td>- Death due to cardiovascular causes in patients after ACS or PCI (2 RCTs, 411 pts)</td>
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<td>- Death due to cardiovascular causes in persons with CKD at risk for or with stable cardiovascular disease</td>
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<td>RR 0.89 (0.75-1.05; P = 0.48)</td>
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<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>Sample Characteristics</td>
<td>Outcomes</td>
<td>Design Characteristics</td>
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<td>Saito et al.</td>
<td>2011</td>
<td>RCT</td>
<td>Diagnosis of type 2 diabetes mellitus. Age between 30 and 85 years. Ability to provide informed consent. History of heart disease. Use of antithrombotic therapy (aspirin, ticlopidine, cilostazol, dipyridamole, trapidil, warfarin, and argatroban).</td>
<td>- Atherosclerotic events of fatal and nonfatal ischaemic heart disease, stroke, and peripheral arterial disease in pts with eGFR 60–89 mL/min/1.73 m²</td>
<td>Random sequence generation and allocation concealment unclear. Participants, personnel not blinded. Outcome assessors blinded. Primary outcomes adequately assessed. 7% lost to follow-up. ITT analysis. All expected outcomes measured in all subjects</td>
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<td></td>
<td>2002–2008</td>
<td>Asia (163 centres)</td>
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<td>-2008</td>
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<td>Unblinded, not-placebo controlled study</td>
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<td>Wang et al.</td>
<td>2010</td>
<td>Systematic review of RCTs or quasi-RCTs</td>
<td>Any type 1 or type 2 diabetic patient with abnormal urinary albumin excretion rate. ESKD, other renal diseases, gestational diabetes.</td>
<td>- Change in serum creatinine - Change in urinary albumin excretion - Change in proteinuria</td>
<td>Only six reports found. All six studies stated that participants had been randomized, but no studies described the method of randomisation in detail. Blinding was not mentioned in any of the included studies. No studies reported a sample size calculation.</td>
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