Conclusion

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This compendium provides an important and timely update for clinicians, reviewing many important considerations for improving clinical outcomes in patients with type 2 diabetes and chronic kidney disease (CKD). It is important to remember that, from an epidemiological standpoint, people with type 2 diabetes and CKD are much more likely to suffer from cardiovascular events than they are to reach end-stage renal disease. In fact, they are five times as likely to succumb from cardiovascular disease than to require renal replacement therapy. With improved opportunities to identify patients earlier in their course of disease and those with increased risk factors for progression, we may be in a better position than ever to implement primary rather than only secondary prevention strategies.

Unfortunately, most of the available data in this arena are from clinical trials focusing on secondary prevention in patients who have already lost more than half of their original kidney function. In large part, secondary prevention studies have been the norm because these studies tend to be shorter and more cost-effective for providing the hard endpoints needed for regulatory approval with specific indications. On the other hand, in clinical practice, primary prevention is a much more important opportunity to make a substantial difference in the quality and duration of our patients' lives. We therefore hope this compendium will be important to readers, not only by describing more precise, evidence-based approaches for disease progression mitigation, but also by helping them adopt and optimally implement both traditional and newer therapeutic options to improve clinical outcomes. Additionally, we hope this opportunity to understand more about risk factors, biomarkers, and phenotyping of patients who are more likely to exhibit kidney disease progression will encourage readers to focus not only on secondary intervention, but also on primary prevention of CKD in their patients with diabetes.

Toward that end, our focus for patients with diabetes and CKD should be on earlier identification, education, and intervention using guidelines-based and carefully individualized approaches. The discussion provided by Dr. Keith C. Norris (p. 19) about the need to correct disparities in clinical care is also a particularly important consideration for diabetic kidney disease treatment. So, too, is the current conversation about the potentially deleterious effect of modifying GFR estimation equations based on patients' race and whether this practice should be halted to reduce bias and inequities in the timely provision of appropriate treatment.

In the meantime, it is encouraging that we now have more therapeutic opportunities. Moving forward, it will be important for our patients to have access to newer therapies and the ability to avoid the pitfalls of prescription regimens that require substantial out-of-pocket copayments and laborious prior authorizations. We hope readers will find the data and practical strategies presented throughout this compendium helpful in their clinical practice and that they will appreciate and embrace the wealth of new clinical options to improve the health and lives of their patients with type 2 diabetes and CKD.

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