RESULTS: We included 563 patients initially. Among them, 74 patients (13.1%) with diabetes were included for analysis, including the changes in fasting plasma glucose (FPG) levels and adverse events (AEs). Patients were divided into two groups: the SALT group (n: 195) and the LOWSALT group. The remaining 205 patients in the LOWSALT group. Patients were divided into groups according to their daily salt intake. Patients receiving more than 5.9 grams of salt a day were taken to the SALT group. (n: 195). The remaining 205 patients in the LOWSALT group. Patients were divided into two groups: the SALT group (n: 195) and the LOWSALT group. ACR (95 mg/g vs. 417 mg/g, p < 0.001), HbA1c (7.9 ± 2 % vs. 8.8 ± 3 %, p < 0.001), FBG (161 ± 63 mg/dl vs. 201 ± 92 mg/dl, p < 0.001) were higher in the LOWSALT group. Despite the rate of retinopathy was lower (8.4% vs. 16.7%, p < 0.014) in the SALT group, the diabetic foot and neuropathy were found more commonly in the LOWSALT group. Who take the lowest amount of potassium (POT 1), also take the lowest amount of salt at the same time (Table). CONCLUSIONS: The correlation between salt consumption and glucose regulation and microvascular complications was found as inversely. Glucose regulation, kidney injury and other microvascular complications were reduced as potassium intake was increased. Since low potassium intake and low sodium intake are together in patients, albuminuria and microvascular complications might be less common in the LOW SALT group. Increasing potassium intake in diabetic patients without renal insufficiency might be helpful in reducing diabetic microvascular complications.

**IS THERE ANY RELATIONSHIP BETWEEN DIABETIC MICROVASCULAR COMPLICATIONS AND DAILY INTAKE OF SODIUM AND POTASSIUM CALCULATED BY URINE SODIUM AND POTASSIUM EXCRETION**

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**INTRODUCTION AND AIMS:** In this study, we aimed to investigate whether there is a relationship between daily salt and potassium intake and diabetic microvascular complications.

**METHODS:** For this study, 562 consecutive patients who admitted to the outpatient clinic were recruited in a period for 2 months. Four hundred patients remained after excluding of patients that had with eGFR <60 ml/ min / 1.73 m2, heart failure, diuretic using, electrolyte imbalances, hormonal dysfunctions, malignancies. Sodium, potassium, creatinine, and albumin were measured from the first voided urine of patients. Albumin creatinine ratio, salt excretion in grams by multiplying correction factors by spot urine sodium were calculated. Also, FBG, creatinine, serum electrolyte, lipid profile, HbA1c, serum albumin were detected. All demographic data and BMI’s were recorded. Retinopathy, diabetic foot and neuropathy were investigated by self-reported of patients and hospital records. Patients were divided to groups according to daily salt intake. Patients receiving more than 5.9 grams of salt a day were taken to the SALT group. (n: 195). The remaining 205 patients in the LOWSALT group. Patients were divided into groups according to their daily salt intake: FBG, HbA1c level and ACR levels are significantly lower. Diabetic foot and neuropathy were also less common in the POT 4. Patients who take the lowest amount of potassium (POT 1), also take the lowest amount of salt at the same time (Table). CONCLUSIONS: The correlation between salt consumption and glucose regulation and microvascular complications was found as inversely. Glucose regulation, kidney injury and other microvascular complications were reduced as potassium intake was increased. Since low potassium intake and low sodium intake are together in patients, albuminuria and microvascular complications might be less common in the LOW SALT group. Increasing potassium intake in diabetic patients without renal insufficiency might be helpful in reducing diabetic microvascular complications.