Letter and Reply

Non-diabetic nephropathy in diabetics

To the Editor,

In previous studies, most researchers tried to find predictors to differentiate nondiabetic renal diseases (NDRDs) from diabetic nephropathy in diabetic patients. As the chronology is variable, it is not easy to predict NDRDs in patients with diabetes, especially type 2 diabetes. Absence of retinopathy, short duration of diabetes, presence of hematuria, and heavy proteinuria in preserved renal function have been reported as predictors. These factors can help nephrologists select patients for kidney biopsy [1].

The renal outcome of NDRDs in diabetic patients is not clear. Kim et al [2] reported that patients with NDRDs had better prognosis than those with diabetic nephropathy. The patients who were treated with immunosuppressants showed better renal outcomes. These results are similar to the findings of a recent study conducted in Korea [3].

However, until now no clinical trials have been conducted to evaluate the effectiveness of immunosuppressants in patients with NDRDs. Although immunosuppressants may have positive renal outcomes, their side effect is not avoidable. Therefore, the risks and benefits of immunosuppressants should be considered.

Conflicts of interest

The author declares no conflicts of interest.

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In Reply:

We appreciate your interest in our recent article entitled "Non-diabetic kidney diseases in type 2 diabetic patients." Diabetic nephropathy is one of the most common causes of end-stage renal disease in Korea. It is typically diagnosed based on the clinical history of proteinuria in a patient with diabetes. Renal biopsy has been recommended for type 2 diabetic patients with atypical nephropathy because a considerable number of these patients may have nondiabetic nephropathies [1]. Other causes of renal disease in diabetes should be considered in the presence of any of the following circumstances: absence of diabetic retinopathy, low or rapidly decreasing glomerular filtration rate, rapidly increasing proteinuria or nephrotic syndrome, refractory hypertension, presence of active urinary sediment, signs or symptoms of other systemic diseases, and rapid reduction in glomerular filtration rate within 2–3 months following the initiation of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker [2].

As Byun et al [3] recently reported, findings of renal biopsies from type 2 diabetic patients with renal disease in Korea showed that these patients comprise a heterogeneous group of disease entities, some of which are remittable and some treatable. Our data also revealed various renal diseases in diabetic patients with nondiabetic nephropathy. Membranous nephropathy, IgA nephropathy, and acute tubulointerstitial nephritis were the three most common pathologic findings.

As you pointed out, it may not be easy to conclude that renal outcomes of nondiabetic nephropathy are better than those of diabetic nephropathy because of the heterogeneous disease entities. In addition, the side effects of intensive treatment with corticosteroids and/or immunosuppressants are considerable, although these therapies may have positive renal outcomes in some patients with NDRDs. Until now, no clinical trials have been performed evaluating the effectiveness of immunosuppressants or no clinical practice guidelines have been established for diabetic patients with nondiabetic glomerular diseases. However, it would be important not to miss a case that is treatable or remittable with corticosteroids and/or immunosuppressants. I believe that if the benefits of such intensive treatment outweigh its risks, the treatment
should be considered in patients with type 2 diabetes having aggressive NDRDs.

**Conflicts of interest**

The author declares no conflicts of interest.

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Available online 21 February 2014