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The Natural History of Diabetic Kidney Disease and Treatment of Hyperglycemia in Patients with Type 2 Diabetes

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Abstract

Person with blood sugar disease I.e. Diabetes Mellitus (DM) organ that creates urine disease develops in about 40% of patients who are DM and is the leading cause of CKD worldwide. Although ESRD may be the most able to be known because of previous knowledge result of DM organ that creates urine disease, most patients actually die from disease of the heart and blood vessels and infections before needing organ that creates urine replacement therapy. The natural history of person with blood sugar disease, DM organ that creates urine disease includes glomerular hyperfiltration, progressive milk proteinuria, lowering in number GFR, and in the end, ESRD. Related to processing and using food changes connected with disease where blood sugar swings wildly leading to glomerular too much growth, glomerulosclerosis, and tubule interstitial swelling and fibrosis. Even though there is the existence of current therapies, there is large leftover risk of person with blood sugar disease, DM, organ that creates urine disease beginning and development or increase over time. Therefore, existing all over a large area invention of new things is very much needed to improve health results for patients with person with blood sugar disease organ that creates urine disease.

Keywords: CKD • Diabetes mellitus • ESRD • DKD • GFR

Introduction

Person with blood sugar disease, DM organ that creates urine disease (DKD) remains as the most common cause of end-stage kidney-related disease (ESRD) in US and most countries. Over the last few years, the range of DKD has been changed and got better. Our understanding of DKD how a disease started has been also advanced significantly. Sodium-glucose co-transporter-2 (SGLT2) stoppers have been approved as new drugs to treat patients with DKD. Also, more than two, but not a lot of) new drugs have been in scientific fact-finding experiments with some success [1]. Therefore, we believe that it is the time to write this review to update the current understanding of medicine-based visible signs, disease development or increase over time or things, disease-related changes, and management of DKD patients in the new time in history. Typical medicine-based visible signs of DKD include milk proteinuria, which goes forward to macro albuminuria or obvious proteinuria over time, tiny blood in the urine, which presents only in a small part of patients, and a low development or increase over time of events or things rate of kidney-related function. Classically, DKD is divided into 5 stages [2]. The stages 1 and 2 are preclinical stages, seen as an increase of glomerular filtration rate (GFR), norm-albuminuria (stage 1) or on-and-off micro-albuminuria (MA; stage 2), and commonly and healthy blood pressure. Stage 3 is the beginning of medicine-based stage, seen as not going away MA, mild high blood pressure, and an commonly and healthy or short decline in GFR. Stage 4 is seen as macro-albuminuria, high blood pressure, and further decline of GFR. Stage 5 is the end stage of kidney-related disease. However, recent related to the study of what causes disease studies suggest that not all patients with DKD follow the above classification, especially in patients with type 2 diabetes [3]. Compared with proteinuric DKD, nonproteinuric DKD showed about a weaker association with diabetes, eye disease. All the findings may suggest a nonalbuminuric pathway for the development or increase over series of events or things of DKD. Prevention of diabetes difficulties, especially DKD, by long-term intensive glycemic control from early in the course of disease where blood sugar swings wildly is done or used by many people for DM1 and DM2. However, intensive glucose control after beginning of difficulties or in existing for a long time disease where blood sugar swings wildly has not been shown to reduce risk of DKD development or increase over series of events or things or improve overall medicine-based results. A small benefit of intensive glycemic control on the risk of ESRD was followed, but the complete and total number of patients was minute. An in separate layers analysis showed that the greatest benefit of intensive glycemic control for preventing ESRD was seen in people who were part of a study, etc. without organ that creates urine disease at study entry, further supporting the idea that intensive glycemic control started during early disease where blood sugar swings wildly can prevent DKD.

Conclusion

Since the discovery of insulin in the 1920s, research has made significant long steps toward understanding and improving the medicine-based management of disease where blood sugar swings wildly. Although these advances have meaningfully improved results for disease where blood sugar swings wildly difficulties, such as CVD, these improvements have not translated nearly as well to DKD or ESRD. In response, the International community of people in the world of Nephrology has met a Worldwide organ that creates urine Health Effort to begin doing something to call attention to organ that creates urine sicknesses overall. Key group working well together people who are interested in a project or business in the search to fight DKD should include patients, health care providers and payers, groups of people who fight for fair treatment, scientists, and governmental services businesses. Fighting for something and a call to action are extremely important to effective spreading around and putting into use of current best practices. Using public health and population approaches in medicine-based practice and promoting meaningful and related to a plan to reach a goal research will be key to improving health results for people with disease where blood sugar swings wildly and DKD.

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