

Correspondence

Comment on: The current practice of using angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers in diabetic hypertensive and non-hypertensive patients. Is there a room for vitamin D?

To the Editor

I have read with interest the article by Sukkarieh et al,¹ about the current practice of angiotensin-converting enzyme inhibitors (ACEi) and angiotensin receptor blockers (ARB) in patients with diabetes mellitus with nephropathy whether they were suffering from hypertension or not? And if vitamin D supplement has room in the management of diabetic nephropathy or not? It's noteworthy, that diabetic nephropathy is an old terminology used historically to indicate the presence of albuminuria in patients with type 1 diabetes mellitus and retinopathy.² Currently, diabetic kidney disease has replaced diabetic nephropathy which includes conditions with persistent albuminuria, low Estimated glomerular filtration rate (eGFR), or any manifestations of kidney damage in patients with diabetes mellitus.³

Renin-angiotensin system (RAS) inhibition is considered the cornerstone part of the management of diabetic kidney disease. It has been shown the benefit of these drugs is beyond the blood pressure-lowering effect, as they also reduce proteinuria and slow the progression of kidney disease. Monitoring the renal function including creatinine and potassium level after starting the ACEi or ARB is recommended by different guidelines, however, it is not commonly implemented in the clinical practice either because of lacking the knowledge about its importance or working in a busy clinic with a long period of follow up.^{3,4} However, in this study by Sukkarieh et al,¹ most of the participating physicians (70%) agreed about monitoring the renal function before and after starting ACEi or ARB. One additional important point mentioned in this study is the combination of RAS inhibition drugs. Although the literature emphasized the combination of both ACEi and ARB carries an increased risk of hyperkalemia, this cohort found the use of such a combination was as high as almost 30%.⁵

Vitamin D supplement is part of the management of patients who require renal replacement therapy due to chronic kidney disease. Is there strong evidence about the use of vitamin D in patients with diabetic kidney disease without renal impairment? There is uncertainty about the benefit of vitamin D supplements in patients with diabetic kidney disease and preserved renal function. In

this study, almost 50% of the participating physicians did not think that vitamin D can help patients with diabetic nephropathy. Vitamin D deficiency is common in our community with a prevalence of 60% in one report.⁶ So, if someone tries to link it to any disease, it might give a positive relationship. However, it is not necessarily indicating the treatment with vitamin D would make a difference in management.

One of the major limitations of the study by Sukkarieh et al,¹ that most of the participating physicians were internists or family medicine doctors while endocrinologists accounted for less than 10% and nephrologists for 6%. Such selection might not truly represent the exact physicians who deal with the problems related to diabetic kidney disease.

Finally, I would like to thank Sukkarieh and colleagues for their great study which illustrates the practice of using such important medications as ACEi and ARB in patients with diabetic kidney disease.

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Reply from the Author

No reply was received from the Author.

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