Foreword

DIABETIC NEPHROPATHY: A NEPHROLOGICAL POINT OF VIEW

Some years ago, the nephrologist was only concerned with diabetic patients affected by acute events such as metabolic disturbances and infection. As an immunologist, he was also involved in research on the pathophysiology of Type 1 diabetes. However, aggressive coronary angioplasty and heart surgery, as well as data in epidemiological registries, revealed the dramatic prevalence of diabetic patients among those requiring dialysis for end-stage renal failure. In France, the incidence of new patients with diabetes and terminal renal failure has doubled in less than ten years and is still progressing at the same rate.

At the present time, a patient with Type 2 diabetes complicated by nephropathy will show concomitant progress to end-stage renal failure, heart failure, coronary heart disease, proliferative retinopathy, peripheral ischaemic arterial disease, neuropathy and other extensions of the disease. The management of such patients will partially escape the diabetologist’s supervision, although his skills should be frequently needed since it is obvious that every haemodialysis session induces dramatic changes in the milieu intérieur and physiological regulation. To limit these comorbidities and improve prognosis, the nephrologist needs to be involved very early in the care of the diabetic patient. In practical terms, the main problems are reduced to two considerations:

1) The combination of patient follow-up with the diabetologist’s care.

2) The treatment of patients with no previous renal examinations who are seen for the first time in the intensive care unit with terminal renal failure, coma, cardiopulmonary failure, hyperglycaemia and acidoketosis.

The possible solutions are numerous, emphasising the need for a better exchange between the specialties involved and indicating the context for continuing medical education of general practitioners. I would like to focus on four points in order to document the many fields of common interest:

Firstly, better and earlier diagnosis of diabetes appears to be a prerequisite to any improvement in the management of nephropathy. A basic understanding of the very few variables needed to assess renal involvement deserves some comment. Generally, renal involvement is detected during the diagnosis of hypertension, which leads to measurement of proteinuria and serum creatinine. Both the technical conditions of sampling and the clinical background need to be carefully checked. Consequently, proteinuria (or albuminuria) should be expressed as a rate per unit of time, and creatinine as a clearance rate adjusted for age, weight, sex or body surface area, even when using internationally known indexes such as the Cockcroft and Gault formula.

Secondly, the progression of renal insufficiency should be carefully monitored, and supportive therapy should be presented and explained to the patient and his family. If this policy is followed, errors in understanding so-called near-normal serum creatinine can be avoided, and a large number of patients with latent renal insufficiency can be recruited. Adequate control of hypertension is the best recognised treatment for decreasing the progression rate to end-stage renal failure. However, this treatment is not unique, and many other disturbances associated with chronic uraemia need to be taken into account, such as the correction of anaemia and chronic acidosis, prevention of renal osteodystrophy, and dietary interventions. Nevertheless, the dramatic mismanagement of chronic renal insufficiency should also be considered. In this setting, we may note the severe risk of death in end-stage renal failure patients with diabetes, which is not known to nephrologists but was recently documented in Strasbourg by Thierry Hanedouche’s team. These patients have a four- to five-fold higher risk of death in the three months following the start of chronic dialysis than do diabetic patients adequately followed and programmed for dialysis.

Thirdly, the diabetic patient with chronic renal failure is, even for the nephrologist, a very distinct patient, because he has escaped acute metabolic complications and is presently well-managed by the cardiologist. The diabetic patient with terminal renal failure is always very disabled, and his condition combines many comorbidities, as in the picture described by North-American nephrologists some ten years ago.
The clinical care of these patients is so time-consuming that it seems quite impossible to treat them at home or in self-care dialysis units. Consequently, care (what may be called the “medical dose”, which includes medical and nursing duties) and economic allocation are changing. We need to convince our government and social insurance managers of the reality of this evolving landscape and its real cost. The quality of care needs to be adjusted to the needs of the diabetic patient, and quantitative evaluation of this group of patients requires exhaustive epidemiological studies. We consider that the amount of money allocated to dialysis must not be measured solely according to criteria based on economic indexes but also (and mainly) on criteria describing the patient and his ongoing pathology. The only defence we have as physicians is to request our scientific societies to define the references for the best good practices established according to the best available methodology. This is precisely what our societies are doing under the coordination of Daniel Cordonnier. As President of the Society of Nephrology, I would like to congratulate all those diabetologists and nephrologists, who participated in this project, which will soon be published. A last step is required if we are to become stronger in front of the “Administration”: to obtain definite approval for our institute of accreditation, the ANAES.

The fourth and last point concerns the ethical aspects of our practice. Dialysis is currently a technique available everywhere, which is handled well by efficient specialists and well-trained nurses, who provide life-support regardless of the physical and cognitive restrictions of the patient with diabetes and chronic uraemia. “Quality of life” is poorly defined in dialysed patients since appropriate indexes have not been validated, at least in France. We need well-designed questionnaires and suitable scales to define the evolving clinical status of our patients. We also need continuous exchanges with the patient’s family and the general practitioner. Together, we may find solutions in extreme conditions requiring ethical support, such as palliative therapy, dialysis withdrawal, and suicide.

I am confident that this meeting will improve our mutual understanding of the diabetic patient and unanimously support the proposed guidelines for the best clinical practice.

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