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SHORT COMMUNICATION

The Differentiations of Nutrition Status in Dialysis and Diabetes Patients

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INTRODUCTION

One of the major causes of non-communicable disease mortality is Chronic Kidney Disease (CKD), but there are few nephrologists in the world. A method of collaboration between primary care doctors and nephrological facilities, which include nephrologists and multidisciplinary care teams, is known as medical cooperation. There aren't many studies on the impact of a medical collaboration system, despite reports that interdisciplinary care teams help avoid deteriorating renal functions and cardiovascular events. Methods: Our goal was to assess the impact of medical collaboration on kidney prognosis and overall cause-specific mortality in CKD patients. From December 2009 as well September 2016, 166 patients were enrolled, of whom 133 were categorized toward a medical cooperation group. These patients visited the 166 clinics and 7 general hospitals in Okayama city. A renal composite result (end-stage renal disease or a 50% drop in eGFR) or the occurrence of all-cause mortality was used to determine the outcome. In a Fine-Gray subdistribution hazard model, we assessed the impacts on the renal composite consequence and pre-ESRD mortality while accounting for the competitive risk for the alternative outcome.

DESCRIPTION

End-stage kidney disease is presently most commonly caused by diabetes mellitus. Assessing nutritional health is an essential component of treatment in this population. This prospective observational study sought to examine the relationship between hospitalisations and all-cause mortality and the nutritional status of people with type 1 and type 2 diabetes receiving hemodialysis or peritoneal dialysis. The study included adult patients with type 1 or type 2 diabetes receiving insulin treatment and end-stage renal disease receiving dialysis. Other forms of diabetes, the patient's refusal to take part in the study, and major illnesses that impair verbal-logical communication were among the exclusion criteria. For 95 Caucasian dialysis patients who had either type 1 (n=25) or type 2 (n=70) diabetes, the dietary state was assessed using the dietary Risk Index, the Geriatric Nutritional Risk Index, measurements of the distribution of fat, and the Charlson Comorbidity Index. Patients with type 1 diabetes showed substantially poorer nutritional state and higher risk factors for nutrition compared to those with type 2 diabetes. With 84% sensitivity and specificity, lower nutritional markers substantially distinguished individuals with type 1 diabetes from those with type 2 diabetes. All-cause hospitalizations were linked to poor dietary status, whereas cardiovascular hospitalizations and all-cause mortality were linked to increased comorbidity.

Dialysis patients with type 1 and type 2 diabetes should not be viewed as a homogenous group, especially given the older age of type 2 diabetes patients. This is because there is a substantial variation between these patients. The most common cause of end-stage renal failure needing renal replacement treatment right now is diabetes mellitus (DM). Previous research involving diabetic dialysis patients has divided treatment options into Hemodialysis (HD) and Peritoneal Dialysis (PD), without taking into account the patients' specific types of diabetes. Although variations among them have not been examined, this is likely because of the disparity in group size between individuals with type 1 and type 2 diabetes, which is sometimes mentioned in the research group's characteristics. While type 1 DM is less prevalent, it impacts 90%-95% of people with diabetes in the general community and those who need renal replacement treatment. Even fewer individuals have other forms of diabetes. When evaluating dialysis patients, it appears that type 1 and type 2 diabetes, which are separate illnesses with pathogenesis and clinical progression, go unnoticed from a nephrological viewpoint [1-4].

CONCLUSION

Patients with type 1 diabetes had worse dietary state and were at higher nutritional risk among Caucasian patients with type 1 or type 2 diabetes mellitus who were receiving dialysis treatment. Patients with type 1 diabetes and patients with type 2 diabetes were distinguished from one another substantially by lower nutritional scores values. In

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this patient group, the NRI and GNRI are useful instruments for evaluating nutritional health and nutritional risk as well as for predicting all-cause hospitalizations. These patients shouldn't be viewed as a homogenous group due to the numerous notable variations between type 1 and type 2 diabetics receiving dialysis treatment. But compared to type 2 diabetes, which is typically found in much older individuals, type 1 diabetes causes younger patients with the disease to experience a higher metabolic and nutritional derailment.

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CONFLICTS OF INTEREST

Author declares that there are no conflicts of interest.

REFERENCES

1. Ahn SJ, Choi EJ (1999) Renal replacement therapy in korea-insan memorial registry 1997. The Korean J Nephro 18:1–15.
2. Aoyagi T, Naka H, Miyaji K (2001) Body mass index for chronic hemodialysis patients: Stable hemodialysis and mortality. Int J Uro 8:S71–S75.
3. Avram MM, Mittman N, Bonomini L, Chattopadhyay J (1995) Markers of survival in dialysis: A seven-year prospective study. Am J Kidney Dis 26:209–219.
4. Beto JA, Bansal VK (2004) Medical Nutrition therapy in chronic kidney failure: Integrating clinical practice guidelines. J Am Diet Assoc 104:404–409.