

SIMPÓSIO: Abordaje de las comorbilidades y la enfermedad cardiovascular en la persona con diabetes tipo 1

Coordinador: León Litwak

Nefropatía y albuminuria: la entrada al riesgo cardiovascular. Uso de ISRAA y fármacos nefroprotectores

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La enfermedad renal crónica (ERC) en la diabetes mellitus tipo 1 (DM1) debe interpretarse como parte del continuo cardiorrenal y no solo como una complicación microvascular. Su detección se basa en la relación albúmina/creatinina urinaria (RAC) y la tasa de filtrado glomerular estimada (TFGe), con rastreo desde los 5 años del diagnóstico y confirmación de todo resultado anormal. La presentación es heterogénea: la TFGe puede disminuir antes de la albuminuria; sin embargo, en estudio FinnDiane la enfermedad renal no albuminúrica representó solo el 2%, mientras que la combinación de albuminuria y TFGe <60 ml/min/1,73 m² identificó el mayor riesgo cardiovascular y de mortalidad. La regresión de la albuminuria se asoció con menor riesgo renal y cardiovascular. No obstante, el 63% de las personas con DM1 y ERC no alcanzaba simultáneamente las metas de presión arterial, colesterol y HbA1c¹.

La albuminuria es considerada actualmente un marcador de daño renal, un factor de riesgo vascular y un objetivo terapéutico. El bloqueo del sistema renina-angiotensina-aldosterona (SRAA) continúa siendo parte del tratamiento fundacional. En la ERC, ante hipertensión o RAC ≥ 30 mg/g debe indicarse un IECA o un ARA II, titulado hasta la máxima dosis tolerada, con control de presión arterial, creatinina y potasio a las 2-4 semanas².

Más allá del SRAA, la evidencia nefroprotectora en DM1 se amplía, aunque no es uniforme. En datos de vida real, los inhibidores de SGLT2 se asociaron con preservación de la TFGe y menos insuficiencia cardíaca, ERC y hospitalizaciones que los agonistas GLP-1, pero con más cetoacidosis diabética e infecciones urinarias, lo que exige selección cuidadosa, educación y monitorización de glucosa y cetonas³.

Diferentes estudios recientes van reconociendo los beneficios en control metabólico, peso y factores de riesgo CV de los ARGLP1 en DM1, y algunos resultados indirectos en reducción del riesgo de MACE y de enfermedad renal avanzada⁴. En FINE-ONE, ensayo aleatorizado, doble ciego y controlado con placebo, 242 personas con DM1, ERC, RAC de 200–5000 mg/g y tratamiento con inhibidores del SRAA recibieron finerenona durante seis meses; la RAC se redujo 25% frente a placebo⁵. En conjunto, el objetivo terapéutico integra tres metas: disminuir el riesgo cardiovascular, reducir la albuminuria y enlentecer la caída del filtrado glomerular.

Bibliografía

1. Jansson Sigfrids F, Lithovius R, Groop PH, Thorn LM. Lessons learned from the FinnDiane Study: Epidemiology and metabolic risk factors for diabetic kidney disease in type 1 diabetes. *Diabet Med*. 2025;42(2):e15431. doi:10.1111/dme.15431.
2. Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. KDIGO 2024 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. *Kidney Int*. 2024;105(Suppl 4S):S117-S314.
3. Anson M, Zhao SS, Austin P, Ibarburu GH, Malik RA, Alam U. SGLT2i and GLP-1 RA therapy in type 1 diabetes and reno-vascular outcomes: a real-world study. *Diabetologia*. 2023;66(10):1869-1881. doi:10.1007/s00125-023-05975-8.

4. Garg SK, Akturk HK, Battelino T, et al. Adjunctive treatment with GLP-1 and dual GLP-1/GIP receptor agonists for people with type 1 diabetes: Consensus report and practical guidelines for safe use. Diabetes Technol Ther. Published online June 5, 2026. doi:10.1177/15209156261449879.

5. Groop PH, Tuttle KR, Rossing P, et al. Finerenone in Patients with Type 1 Diabetes and Chronic Kidney Disease. N Engl J Med. 2026;394(10):947-957.

Palabras clave: nefropatía; albuminuria; fármacos.

SYMPOSIUM: Addressing comorbidities and cardiovascular disease in people with type 1 diabetes

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Nephropathy and albuminuria: the gateway to cardiovascular risk. Use of RAAS inhibitors and nephroprotective drugs

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Chronic kidney disease (CKD) in people with type 1 diabetes (T1D) should be regarded as part of the cardiorenal continuum rather than solely a microvascular complication. Screening is based on the urinary albumin-to-creatinine ratio (UACR) and estimated glomerular filtration rate (eGFR), beginning five years after diagnosis, with confirmation of any abnormal finding. CKD presentation is heterogeneous, as eGFR may decline before the onset of albuminuria. However, the FinnDiane Study showed that non-albuminuric CKD accounted for only 2% of cases, whereas the combination of albuminuria and an eGFR <60 mL/min/1.73 m² identified individuals at the highest risk of cardiovascular events and mortality. Regression of albuminuria was associated with lower renal and cardiovascular risk. Nevertheless, 63% of individuals with T1D and CKD failed to simultaneously achieve blood pressure, cholesterol, and HbA1c targets [1].

Albuminuria is now recognized not only as a marker of kidney damage but also as a marker of vascular risk and a therapeutic target. Blockade of the renin–angiotensin–aldosterone system (RAAS) remains the foundation of kidney-protective therapy. In patients with CKD, an angiotensin-converting enzyme inhibitor (ACE inhibitor) or an angiotensin receptor blocker (ARB) should be initiated in the presence of hypertension or a UACR ≥ 30 mg/g, titrated to the maximum tolerated dose, with reassessment of blood pressure, serum creatinine, and potassium within 2–4 weeks [2].

Beyond RAAS blockade, kidney-protective therapies in T1D continue to evolve, although the evidence remains limited. In a real-world study, sodium-glucose cotransporter-2 (SGLT2) inhibitors were associated with better preservation of eGFR and lower rates of heart failure, CKD progression, and hospitalization than glucagon-like peptide-1 receptor agonists (GLP-1 RAs), albeit at the expense of an increased risk of diabetic ketoacidosis and urinary tract infections, emphasizing the need for careful patient selection, patient education, and glucose and ketone monitoring [3]. Recent evidence also supports the use of GLP-1 receptor agonists and dual GLP-1/GIP receptor agonists as adjunctive therapy in T1D, demonstrating benefits in glycemic control, body weight, and cardiovascular risk factors, with emerging evidence suggesting potential reductions in major adverse cardiovascular events (MACE) and advanced kidney disease [4]. In the FINE-ONE randomized, double-blind, placebo-controlled trial, 242 adults with T1D, CKD, a UACR of 200–5000 mg/g, and background RAAS inhibitor therapy received finerenone for six months, resulting in a 25% reduction in UACR compared with placebo [5].

Overall, contemporary management of diabetic kidney disease in T1D integrates three complementary therapeutic goals: reducing cardiovascular risk, lowering albuminuria, and slowing the decline in kidney function.

Key words: nephropathy; albuminuria; drugs.