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Monitoring and Management of New-onset Diabetes After Transplant

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Immunosuppressant promotes new-onset diabetes after transplant (NODAT) by inhibiting pancreatic β cell function and peripheral insulin action. NODAT is one of the most common and serious common complications associated with kidney transplant. The incidence is estimated to range from 2% to 53%. It can affect not only allograft outcome, but also other outcomes such as cardiovascular event, patient survival and infection rate. Therefore, it is important to improve the long-term prognosis of KTRs to identify high-risk patients for NODAT, take preventive actions, and apply appropriate treatment.

Blood glucose evaluation for the pre-transplantation period is important for early detection of impaired fasting glucose. Post-kidney transplant patients should have periodical blood glucose monitoring with more frequent assessment in the early phase. In 2009, the Kidney Disease: Improving Global Outcomes (KDIGO) clinical practice guideline added hemoglobin A1C (HbA1C) as part of the screening criteria for NODAT.

If NODAT develops, immunosuppressive regimen modification may be considered to reverse or to improve the diabetes after weighing the risk of rejection and other potential adverse effects. Lifestyle modification and a conventional anti-diabetic approach, as in the type 2 diabetes mellitus guidelines, are also recommended in NODAT management. It may be more difficult to achieve a HbA1c level <7.0% without undue risk and burden in KTRs. Considerable targeting HbA1c is 7.0–7.5%.