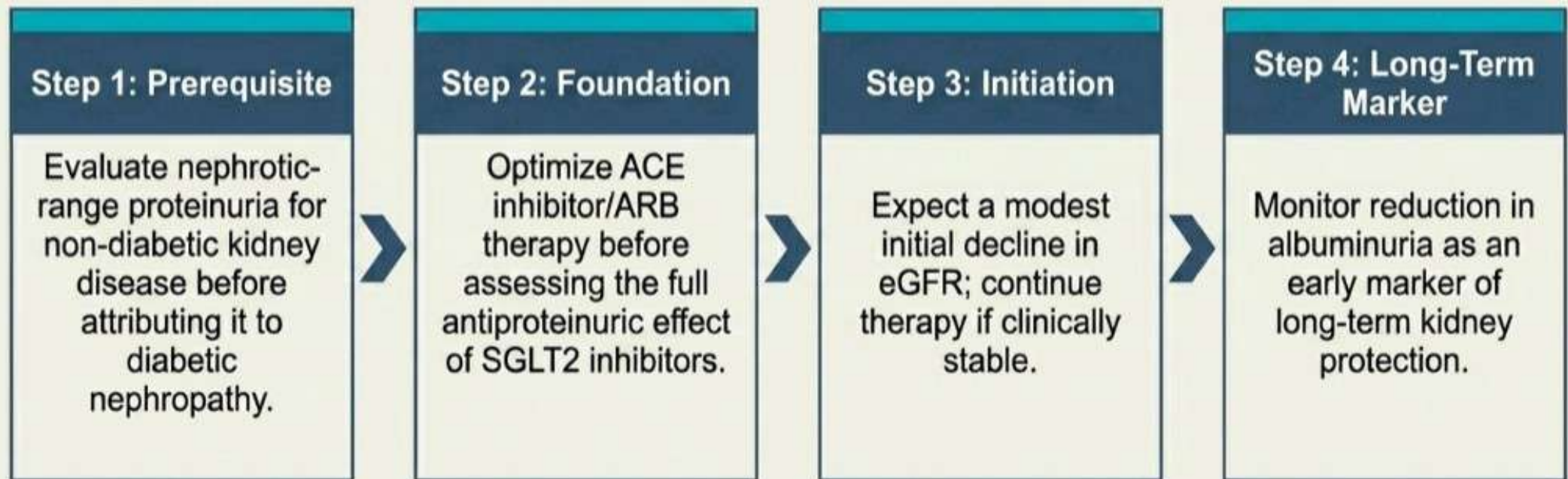


Extracorporeal Nephrology Group (ECNG)

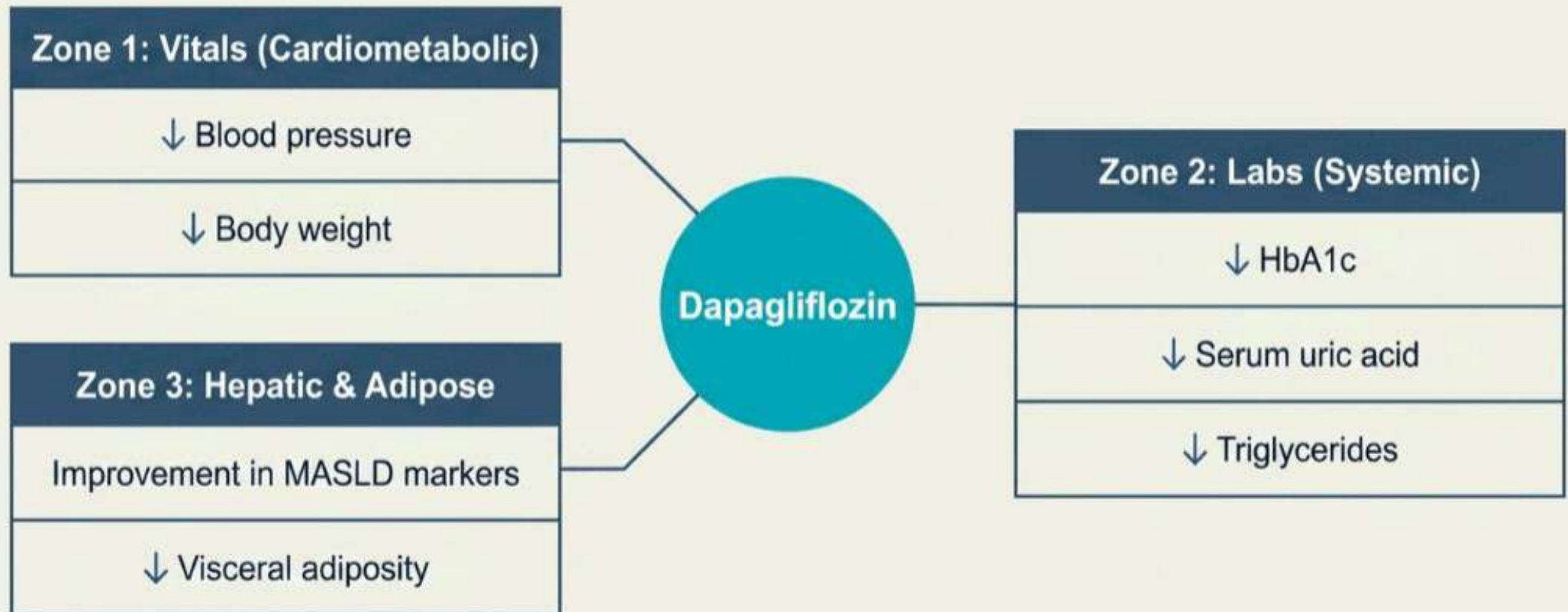
Real-World Wins and Warnings with Dapagliflozin

Dr. Sonu Manuel, Consultant Nephrologist, St. Mary's Hospital, Thodupuzha

Optimizing the renal pathway requires strategic prerequisite evaluation and RAAS blockade



Dapagliflozin operates as a comprehensive cardiorenal and metabolic therapy



A cardiometabolic and renoprotective drug—not merely a glucose-lowering agent.

Treat the infection rather than discontinuing the SGLT2 inhibitor unless clinically indicated

Continue Therapy	Temporarily Withhold	Permanent Discontinuation
✓ Asymptomatic bacteriuria	✓ Pyelonephritis	✓ Recurrent severe UTI despite optimal management
✓ Uncomplicated cystitis	✓ Urosepsis	
	✓ Acute severe illness	

Treat the infection—not the SGLT2 inhibitor—unless clinically indicated.

Euglycemic DKA presents a diagnostic trap disguised by normal glucose levels

The Illusion

Suspect EDKA in patients with:

- Nausea
- Vomiting
- Abdominal pain
- Malaise

The Trap: Normal or mildly elevated glucose

The Reality Check

Remember to check:

- ✓ Ketones
- ✓ Arterial blood gas
- ✓ Anion gap

Sick-Day Rules

Hold: SGLT2 inhibitors during acute illness, dehydration, prolonged fasting, or surgery.

Restart: Only after normal oral intake and clinical recovery.

Maximizing patient outcomes requires balancing proactive initiation with targeted risk management

Maximize Protection

- Initiate SGLT2 inhibitors early in appropriate patients with CKD and diabetes.
- Combine with optimized RAAS blockade for maximal renal benefit.
- Preserve therapy whenever possible—the cardiorenal benefits are substantial.

**Use
confidently—
but use
wisely.**

Minimize Risk

- Most uncomplicated UTIs do not require permanent discontinuation.
- Educate every patient regarding hydration, genital hygiene, and sick-day rules.

The greatest benefit of dapagliflozin
lies not only in prescribing it—
but in knowing when to **continue it**,
when to **pause it**,
and when to **stop it**.