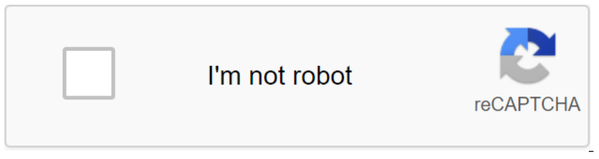
Nefropati hipertensi adalah pdf



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Diabetics have susceptibility to chronic kidney disease. If chronic kidney disease is based on diabetes, then the patient may be diagnosed with diabetic nephropathy. In Indonesia, hypertension and diabetes are believed to be the majority of cases of chronic renal failure. Diabetes mellitus is one of the most numerous contributors to chronic kidney disease in the United States. In 2008, an estimated 44% of patients suffering from chronic kidney disease in the United States were caused by diabetes. Chronic kidney disease occurs 10 years after the patient was diagnosed with type 1 diabetes. Meanwhile, 3% of patients who have recently been diagnosed with type 2 diabetes Mellitus are known to also have complications of chronic kidney disease. Screening and diagnosis of chronic kidney disease in diabetic patients in PPK 1 Guidelines from the American Family Physician recommend screening of chronic kidney disease in patients with type 1 diabetes, starting 5 years after the first patient diagnosed with diabetes. Meanwhile, in patients with type 2 diabetes, screening is carried out from the first diagnosed in a diabetic patient. Screening in PPK 1 is carried out by checking the level of albuminuria in the urine for 24 hours. One of the earliest signs of patients suffering from diabetic nephropathy is if the results of the urine test show 30-300 mg of albumin. If the results of the urine test contain 300 mg of albumin, the patient has undergone macro-anbuminuria. Once a patient is found to be suffering from microalbuminuria or microalbuminuria, patients are advised to perform an albumin urine level analysis each year to assess the progression of the disease and the therapeutic response. Patients should also conduct annual serum creatinine tests and assess the rate of filtration of the glomerular (EGFR) to assess kidney filtration function. Studying the urine of albumin is very easy to do, so it is recommended as a first line screening effort of diabetic nephropathy in PPK 1. Diagnosis of diabetic nephropathy should be done with caution. You should consult an in-house sickness specialist (Sp.PD) to diagnose whether the patient is suffering from diabetic nephropathy, or chronic kidney disease that is not caused by diabetes. It requires ultrasound and ophthalmology (detection of retinopathy). Patients who found micro-anbuminuria or macroalbuminuria were advised to retest 3 and 6 months later. This is done in order to avoid misdiagnosis with reversible kidney symptoms. Serum creatine and EGFR-study will once again confirm whether it is true that the patient has a chronic kidney disease. Final diagnosis Nephropathy is established with a renal biopsy, but this is rare in Indonesia. Glycemic control and hypertension in efforts to prevent nephropathy nephropathy One in eight people with type 1 diabetes and microalbuminuria show the release of urine albumin to be normal again untreated. Key measures to prevent the development of diabetic nephropathy are implemented conservatively, such as efforts to achieve strong glycemic control and lower blood pressure with enzyme angiotensin-conversion inhibitors (ACE) or angiotensin II receptor blockers. The main purpose of the action is to prevent terminal renal failure. Glycemic control to prevent diabetic nephropathy Because about half of people with stage 3 or stage 4 chronic kidney disease have levels of HbA1C qgt;7%, guidelines of the American Diabetes Association (ADA) recommend aggressively controlling blood sugar levels to prevent diabetic nephropathy. Three clinical trials were conducted with large sample numbers and a randomized control trial design to compare intense glycemic control with standard glycemic control. As we suspect, there has been a significant improvement in macroalbuminuria in intensive glycemic control compared to standard glycemic control. However, hypoglycemic cases were reported in patients who received intensive glycemic control. Intensive glycemic control also does not inhibit the progivation of serum creatinine levels or prevent meaningful dialysis. The final levels of HbA1C ranged from 6.4%-6.9% in the intensive control group and 7.3%-8.4% in the standard control group. The study (ACCORD) was also forced to be prematurely discontinued due to serious adverse events causing multiple deaths in intensive control groups. Reflected in some of the above studies, the American Diabetes Association recommends a fairly moderate HbA1C target of 7% in diabetics to prevent diabetic complications of nephropathy. Lower HbA1C goals are allowed as long as doctors can avoid severe complications hypoglycemic. Choosing anti-diabetes therapy based on HbA1C levels can be worked out in our previous article. Blood pressure control to prevent diabetic nephropathy In addition to glycemic control with the goal of HbA1C zlt; 7%, controlling blood pressure up to 130/80 mmHg. may hinder the development of nephropathy. More than two-thirds of adults with diabetes have blood pressure of 140/90 mmHg. or use hypertension drugs. The observation showed that EGFR diabetic patients with poor control of hypertension and macroalbuminuria decreased to 10 ml/min/1.73 m2 per year. While patients with sugar which have the best control of hypertension, the progressive decline of egfr can be inhibited to 1-4 ml/min/1.73 m2 per year. ACE ACE inhibitors The drug of choice is recommended to reduce the risk of microalbuminuria in people with diabetes. The effectiveness of ACE inhibitors is reported to be better compared to calcium channel blockers in preventing diabetic nephropathy. Angiotensin II receptor blockers are also reported to be highly effective in treating hypertension in improving decreased kidney function compared to other hypertensive drug therapy. Patients with diabetes, microalbuminuria, and hypertension or without it should be given ACE inhibitors or angiotensin II receptor blockers to reduce the development of microalbuminuria. One of the appa inhibitors that has been shown to effectively inhibit the progression of diabetic nephropathy is captopril. A cohort study in 1993 involving 409 patients reported that capopril 3 x 25 mg could reduce the likelihood that patients falling for hemodialysis by nearly 50%. However, 3 out of 207 patients receiving captopril reported experiencing potentially fatal hyperkalemia. The use of ACE inhibitors should be discontinued if creatinine levels are 30 percent above the normal limit in the first two months of therapy (although people with elevated creatinine levels are more than 1.4 mg/dL) or in the case of hyperkalemia (potassium serum levels of more than 5.6 mek/L). Diabetic nephropathy, especially those already in terminal renal failure, is a diabetic complication that not only reduces the patient's quality of life, but also requires high health care costs. The general practitioner in PPK 1 plays a strategic role in preventing diabetic nephropathy in diabetic patients. Good glycemic and hypertension control in diabetic patients will be very helpful in preventing diabetic nephropathy in the future. Can be useful - Sponsored book Content Hit Jakarta Diabetes Meeting There are still 15 formers from 140 exes. You can get buku Proceeding Jakarta Diabetes Meeting 2017 with only 250,000 by contacting (WA) Yahya 08560808083342 or click on this order link Stay 15 of 140 copies. There is bonus access to the group OF WA Diabetes Exchange Expert Mellitus (4 Meetings) which will have a lot of tips on treating diabetic patients in everyday practice under the guidance of Dr. Wahyudi, SpPD. Safe your place now! 2.3.1 Vasodilator2.3.2 Adrenergic Nerve Inhibitor2.3.3 Alpha-bloker2.3.4 Beta-bloker2.3.5 Inhibition ACE2.3.6 Antagonists receptor angiotensin II2.3.7 Central Working antihypertensive2.3.8 Other reduction in blood pressure can reduce the frequency of stroke, stroke, coronial events, heart failure and kidney failure. Possible causes of hypertension (e.g. kidney disease, endocrine causes), supporting factors, risk factors and the absence of some such as left ventricular hypertrophy. Patients should be advised to change their lifestyle Lower blood pressure, and the risk of cardiovascular disease; including smoking cessation, weight loss, reduced excessive alcohol consumption, reduced salt intake, reduced overall saturated fat intake, improved exercise (exercise) and increased consumption of vegetables and fruits. Hypertension in children and adolescents has a profound effect on their health in adulthood. Severe hypertension is rare in newborns, but may appear with symptoms of congestive heart failure with the most common cause of renal disorders, and may also be accompanied by damage to arterial embolism. Antihypertensive indications in children include symptomatic hypertension, secondary hypertension, serious organ damage caused by hypertension, diabetes mellitus, sedentary hypertension, despite lifestyle changes, pulmonary hypertension. The effect of antihypertensive treatment on the growth and development of children is not yet known; treatment can only be provided if the benefits of giving are known with confidence. The drug is used to treat hypertension. The choice of antihypertensive drugs depends on indications and contraindications suitable for the patient; some indications and contraindications of various antihypertensive drugs are as follows (see also in the monograph of each of the following drugs for more information): thiazid (see section 2.2.1) - especially shown for hypertension in the elderly (see description below); contraindicated in gout. Beta bloker (see section 2.3.4) - although no longer preferable for initial treatment of hypertension without complications, other signs include myocardial infarction, angina; Contras include asthma, cardiac blockage. ACE inhibitors (see section 2.3.5) - indications include heart failure, left ventricular dysfunction and diabetic nephropathy; contraindications include renovaccular diseases (see section 2.3.5) and pregnancy. Angiotensin II receptor antagonist (see section 2.5.5.2) is an alternative to patients who cannot tolerate ACE inhibitors due to persistent side effects of dry cough, but angiotensin RECEPTOR ANTAGONISTS II have some of the same contraindications as ACE inhibitors. Calcium antagonists. There are important differences between the different calcium antagonists (see section 2.4.2). Calcium dihydropiridine antagonists are useful in systolic hypertension in older adults, when low-dose thiazides are contraindicated or unbearable (see description below). Calcium antagonists of limited use (e.g. diltiazem, verapamine) may be useful in angina; contraindications include heart failure and heart blockage. Alpha Guy (see section 2.3.3) - possible signs - prostateism; contraindicated for urinary incontinence. drug therapies that can be used in children with hypertension include ACE inhibitors (see section alpha-parner (see section 2.3.3), beta-parener (see section 2.3.4), calcium antagonist (see section 2.4.2) and diuretics (see section 2.2). Information on the use of angiotensin II receptor antagonists in children is still limited. Diuretics and beta guys have a sufficient history of effectiveness and safety in children. It is known that the latest generation of antihypertensive drugs, including ACE inhibitors and calcium antagonists, is safe and effective in short-term studies in children. In difficult to overcome hypertension, additional drugs such as minoxidil (see section 2.3.1) or clonidine (see section 2.3.7) may be given. One antihypertensive drug is often not enough, and other antihypertensive drugs are usually added gradually until hypertension can be controlled. Except in cases where an immediate drop in blood pressure is required, it takes at least 4 weeks of administration time intervals to determine the answer. Antihypertensive therapy in children should begin with one therapy at the lowest dose of the recommended dose; then increases until the desired blood pressure is reached. If the highest dose of the recommended dose is already in use, or once the patient experiences the side effects of the drug, another antihypertensive can be added if blood pressure cannot be controlled. If more than one type of antihypertensive drug is required, it is recommended to separate the product (not in one access), as the experience of pediatric specialists in the use of combination drugs remains limited. The response to antihypertensive treatment may depend on the patient's age and ethnic origin (ethnicity). ACE inhibitors, as well as angiotensin II receptor antagonists, are probably the most suitable early drugs in young Caucasian patients. Afro-Caribbean patients and patients over the age of 55 respond poorly to these drugs, and thiazide and calcium antagonists are early treatment options. For regular treatment of hypertension without complications, beta bloker should be avoided in patients with diabetes, or in patients at high risk of developing diabetes, especially if beta bloker is combined with diuretics tiazid. In situations where two antihypertensive drugs are required, apta inhibitors or angiotensin II receptor antagonists may be combined with thiazide or calcium antagonists. If administration 2 types of drugs are still unable to control blood pressure, thiazides and calcium antagonists can be added. Adding alpha guy, spironolacone, other diuretics and beta guys should be considered for resistant hypertension. In patients with primary hyperaldosterism spironolacone (part 2.5.3). Other actions can be taken to reduce the risk of cardiovascular disease. Aceosal (part 2.7) at 75 75 daily reduces the risk of cardiovascular events and myocardial infarction. Too high blood pressure should be controlled before acetiosal administration. In the absence of contraindications, aceosal is recommended for all patients with cardiovascular disease or patients at risk of cardiovascular disease in the next 10 years at 20% or older and over 50 years. Aceosal is also useful for patients with diabetes (see also section 2.7). In children, the increased risk of bleeding and Reye syndrome should be taken into account. Hippolypide drugs may also be useful in cardiovascular disease or in patients at high risk of cardiovascular disease (see section 2.10). Statins can be useful in older children with a high risk of cardiovascular disease and hypercholysterolemia. HYPERTENSION IN THE ELDERLY. The benefits of antihypertensive treatment have been proven to be up to 80 years old, but at the time of the decision to use the drug is not appropriate when based on age restrictions. In older people who appear healthy, when experiencing hypertension his blood pressure should be lowered. The threshold of treatment is the average diastolic blood pressure ≥ 90 mmHg. art or average systolic blood pressure ≥160 mm Hg. after more than 3-6 months (despite the fact that he underwent therapy without medication). Patients who reach the age of 80 at the time of treatment with antihypertensive should continue treatment. A low dose of thiazide is the first choice of the drug, if necessary with other antihypertensive supplements. SYSTOLIC HYPERTENSION IS ISOLATED. Isolated systolic hypertension (systolic blood pressure ≥160 mmHg, diastolic blood pressure of 90 mmHg) leads to an increased risk of cardiovascular disease, especially in patients over 60 years of age. Average systolic blood pressure is 160 mmHg. Art. or higher for more than 3-6 months (despite the fact that they have undergone therapy without medication) should be reduced in patients over 60 years, even if diastolic hypertension does not exist. Treatment with low-dose thiazides, if necessary with the addition of a beta guy, provides effective results. Calcium antagonists are long-working hiddropiridine recommended when thiazid contrasts or cannot be tolerated. Patients with severe postural hypertension should not receive antihypertensive drugs. HYPERTENSION IN DIABETES. For diabetics, the goal of therapy is to maintain systolic blood pressure of 130 mmHg. art and diastolic blood pressure of zlt;80 mm Hg. However, in some patients, this may not be achievable at this stage, despite receiving the right treatment. Most patients require combined antihypertensive drugs. Hypertension is common in with type 2 diabetes and antihypertensive treatment prevents macro- and microvascular complications. Type 1 diabetes usually indicates a lack of nephropathy due to diabetes. ACE inhibitors (or angiotensin II receptor antagonists) play a special role in the management of nephropathy due to diabetes; In patients with type 2 diabetes, apph inhibitors (or angiotensin II receptor antagonists) may delay the development of microalbuminuria into nephropathy. ACE inhibitors can be considered for use for children with diabetes and micro-albuminomy or kidney proteinuria disease. HYPERTENSION IN KIDNEY DISEASE. The threshold for treatment of antihypertensive in patients with impaired kidney function or sedentary proteinuria is systolic blood pressure ≥140 mmHg. art or diastolic blood pressure ≥90 mm Hg. ст. Оптимальное кровяное давление систолическое кровяное <130 mmhg= dan= tekanan= darah= diastolik=></130> <80 mmhg,= atau= lebih= rendah= jika= proteinuria= lebih= dari= 1= g= dalam= 24= jam.= tiazid= kemungkinan= tidak= efektif= dan= diperlukan= dosis= tinggi= diuretika= kuat.= peringatan= khusus= untuk= penggunaan= penghambat= ace= pada= gangguan= fungsi= ginjal,= lihat= bab= 2.3.5,= namun= penghambat= ace= dapat= efektif.= antagonis= kalsium= dihidropiridin= dapat= juga= ditambahkan.= hipertensi= pada= kehamilan.tekanan= darah= tinggi= pada= kehamilan= dapat= disebabkan= hipertensi= esensial= sebelum= hamil= atau= pre-eklamsia.= metildopa= (2.3.7)= aman= pada= kehamilan.= beta= bloker= efektif= dan= aman= pada= trimester= ketiga.= pemberian= intravena= labetalol= dapat= digunakan= untuk= mengendalikan= krisis= hipertensi;= sebagai= alternatif,= hidralazin= dapat= digunakan= secara= intravena.= penggunaan= magnesium= sulfat= pada= pre-eklamsia= dan= eklamsia= lihat= bab= 9.4.1.3.= hipertensi= yang= meningkat= cepat= atau= hipertensi= yang= sangat= berat.hipertensi= yang= meningkat= cepat= (atau= maligna)= atau= hipertensi= yang= sangat= berat= (misalnya= tekanan= darah= diastolik =>давление 140 мм рт. ст.) требует немедленного лечения в больнице but the condition is not a sign of parenteral antihypertensive therapy. Common treatments should be oral with beta bloker (e.g. atenolol or labatalole) or long-serving calcium antagonists (e.g. amlodipine). In the first 24 hours, diastolic blood pressure should drop to 100-110 mmHg. Then, over the next 2 to 3 days, blood pressure should be lowered to normal with the help of a beta guy, calcium antagonist, diuretic, vasodilator, or ACE inhibitor. A very rapid drop in blood pressure can reduce perfusion of organs, which can lead to brain infarction and blindness, deterioration of kidney function and myocardial ischemia. Rarely is parenteral antihypertensive required; Sodium nitropruzid infusion is the drug of choice when parenteral treatment is required (rare condition). HYPERTENSION EMERGENSI. In children, hypertension occurs in signs such as hypertensive encephalopathy, including seizures. It is important to monitor the drop in blood pressure for 72-96 hours. </80> </80> Infusion may be necessary especially during the first 12 hours to increase plasma volume if blood pressure drops too quickly. Oral treatment should begin as soon as blood pressure is controlled. A controlled reduction in blood pressure can be achieved by intravenous laboratoryol infusion (see section 2.4.3) or nitroprucide sodium (see section 2.3.1). Esmolol (see section 2.4.3) is useful for short-term use and has a short lifespan. In rare severe cases, nifedipine can be used in capsule-ready forms. Capsules. nefropati hipertensi adalah pdf