Review Form 1.6

Journal Name:	**Journal of Pharmaceutical Research International**
Manuscript Number:	**Ms_JPRI_81716**
Title of the Manuscript:	**Implication of Estimated Glomerular Filtration Rate for a rationale management in Type 2 Diabetes Mellitus.**
Type of the Article	**Original Research Article**

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty'**, provided the manuscript is scientifically robust and technically sound.
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PART 1: Review Comments

	Reviewer's comment	**Author's comment** *(if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)*
Compulsory REVISION comments	**GENERAL COMMENTS** Reported research reflects a specific setting that may justify its assumptions. However we assume that: 1 – periodic evaluation of renal function is routine and standard in the care of diabetic patients. 2 – selection of anti-diabetic drugs and insulin according to the renal status is routine and standard in the care of diabetic patients. 3 - Diabetic care is certainly multifactorial, and isolating and emphasizing renal status misses the important point of cardiovascular profile of selected drugs; in fact glibenclamide, glimepiride and gliclazide do not present a favorable cardiovascular profile, given its effects on blood pressure and lipids, present a significant risk for hypoglycemic events and may further deplete insulin reserve or β cell function. They are not recommended as first or second line agents for type 2 diabetics. This, however may be different in some countries or in some settings. 4 – To use only descriptive statistics greatly limits the significance of reported results, since these cannot be evaluated or extrapolated for other settings.	
Minor REVISION comments	**RUNNING TITLE** To avoid the use of certain antidiabetic agents in diabetic care because of renal status, does not imply that other agents are nephroprotective….it simply indicates that in the presence of deteriorating renal function its adverse side effects (not necessarily in the kidney) become unacceptable. **ABSTRACT** - both urea and creatinine are measured in serum; it is difficult to understand why it should be written …Blood urea, Sr creatinine…. - eGFR must be defined when first presented in the abstract - …routine blood glucose investigations was estimated for all the participants….is wrong; it should be were not was, and I assume that they were not estimated but measured in fact. **INTRODUCTION** - line 9 - serum urea and creatinine are certainly not early markers of renal dysfunction in diabetic nephropathy; in fact they are very late markers of renal dysfunction even if they may be the only ones available. - line 12 - measurement of renal parameters can limit the progression of renal function? Measurement of renal parameters certainly does not affect renal function **MATERIALS AND METHODS, pg 2** - It would be better patients and methods since patients are not materials… - inclusion criteria - k/c/o type II diabetes mellitus? What is k/c/o? - exclusion criteria - with no other comorbid conditions? Neither obesity? High blood pressure? Dyslipidemia??? - without any symptoms of renal disease? Symptoms and signs – oligoanuria, polyuria, edemas, hematuria, proteinuria, high blood pressure, asthenia, adynamia, anorexia…. – occur only very late in the course of renal diseases, and can not be used to exclude renal disease….in fact it is a contradiction to state that patients did not present symptoms of renal	

	disease to later find out that more than 20% had eGFR < 60 mL/min. - the CKD-EPI equation must be presented - the CPK-EPI equation as well as most other methods to estimate GFR simply "correct" serum creatinine for sex, ethnicity and age. - only descriptive statistics? Authors must formulate hypothesis and test them using inference statistics; otherwise the work loses much of its importance. For instance the relation between eGFR and body mass index, blood pressure levels….or if there were significant differences regarding changing antidiabetic drugs according to eGFR… **RESULTS, pg 3** - 148 diabetics and 61 (41%) were excluded? Why? Such a high rate of exclusion must be explained. - 87 patients, both sexes, most between 40-59 years; other patient characteristics must be presented….time since diagnosis, body mass index, blood pressure levels, serum lipids, HbA1c, and certainly microalbuminuria... - line 11 - nephroprotective agents is wrong, these agents by no means protect the kidney…other agents simply cannot be used in patients with compromised renal function because of adverse side effects (not in the kidney) - most commonly prescribed drugs were metformin and long acting sulphonylureas? This is not recommended - line 11 - in …24 patients prescriptions were modified based on eGFR and HbA1c values….16 patient prescriptions were replaced…depending on their eGFR values and glucose levels…is this not the same? Deteriorating renal function and poor metabolic control? Or in some patients authors value HbA1c and in other occasional glucose levels? - before eGFR only 1 patient was using insulin? - other antidiabetic drugs – glucosidase inhibitors, glitazones, glinidines, DPPIV inhibitors, GLP-analogs, SGLT inhibitors – are only used after sulphonylureas or if sulphonylureas cannot be used? This is contrary to current guidelines. **DISCUSSION, pg 8** - line 1 - current prescription patterns? As noted above these are not those recommended by current guidelines…. - line 5 - declining eGFR in the age group 20-59 years. A most important confounding factor is time since diagnosis and this is not reported; another very important confounding factor is blood pressure levels and these again are not reported…. - line 10 - current antidiabetic agents are directed towards delaying of the progression of diabetic nephropathy. Antidiabetic drugs are directed to correct metabolic dysfunction thus preventing or delaying micro and macrovascular disease that includes CKD… - line 12 - as noted above antidiabetic drugs are not renal protective…. - line 18 - eGFR is simply computed from serum creatinine….and many laboratories provide the results of blood test with an estimation of GFR…. - line 23 - as noted above you cannot value symptoms and signs of renal disease since they are late evidence of ongoing renal disease…. - conclusion: as noted above, periodic evaluation of renal function and microalbuminuria has long been established In the standard care of diabetic patients… **REFERENCES, pg 9** - old and poor quality; only 7/19 are from the last 10 years and none from the last 5 years; only 6/19 are from top diabetic medical journals	
Optional/General comments		

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PART 2:

	Reviewer's comment	**Author's comment** *(if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)*
Are there ethical issues in this manuscript?	*(If yes, Kindly please write down the ethical issues here in details)*	

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