METHODOLOGY
This study aims to investigate if KFRE risk scores differ significantly among individuals with or without diabetes. We conducted a retrospective study on adults with CKD (eGFR 15-59 ml/min/1.73 m^2) who attended our hospital outpatient follow-up from January to December 2022 with available data for calculation of 4-variable KFREs [age, sex, eGFR, urine albumin-creatinine ratio (uACR)]. Two-sample t-test and Mann-Whitney U test were performed to analyse the difference between the two groups.

RESULTS
Out of 10,391 adults with CKD, 1,823 that fulfilled the inclusion criteria were analysed, with a mean age of 70 years, 52% were male, mean eGFR of 45ml/min/1.73 m^2 and median uACR of 8.4 mg/mmol. Majority (84%) have diabetes with a mean HbA1c of 7.8%. Individuals with CKD and diabetes had lower eGFR, heavier albuminuria and had younger age than those without diabetes (p <0.001). These findings further translate to statistically significant higher KFRE risk scores for individuals with diabetes. For those with eGFR between 30-59 ml/min/1.73 m^2, 9.4% of individuals without diabetes and 14.8% of those with diabetes met the referral criteria for nephrology care when setting a KFRE score threshold of more than 5% over 5 years.

CONCLUSION
The lack of uACR monitoring resulted in a smaller sample size than anticipated. We advocate all healthcare professionals to monitor uACR and utilize the KFRE score in clinical practice when managing CKD or diabetes with eGFR between 15-60 ml/min/1.73 m^2 to guide referral to multi-disciplinary care and raise public awareness about the risk of ESKD.

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THINGS MAY NOT ALWAYS BE AS THEY SEEM

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INTRODUCTION/BACKGROUND
Atypical diabetes and late-onset Type 1 Diabetes Mellitus are rare, affecting only 10% of patients with diabetes. Presence of diabetes-associated autoantibodies such as Anti-Islet Cell (ICA), Anti-Glutamic Acid Decarboxylase (GAD), Anti-Insulinoma Associated Antigen-2 (IA2) and Zinc Transporter 8 (ZnT8) point towards type 1 over type 2 diabetes mellitus.

CASE 1
A 55-year-old male with underlying autoimmune hypothyroidism and vitiligo was admitted for diabetic ketoacidosis (DKA) with the following laboratory findings: HbA1c 16.6%, random blood sugar (RBS) 43 mmol/L, serum ketone 6.7 mmol/L, pH 7.06 HCO3 5.1. He was lean with a body mass index (BMI) of 21 kg/m^2 and no family history of diabetes. He was discharged well with metformin, dipeptidyl peptidase-4 inhibitor (DPP-4i) and basal insulin. Follow-up after two weeks showed erratic glucose control. Results showed positive ICA: 224 IU/ml (>28 IU/ml) and GAD: >280 IU/ml (>17 IU/ml) but negative IA2: 3.611 (<28 IU/ml) and low C-peptide 146 pmol/L (<367 pmol/L). He was diagnosed with latent autoimmune diabetes of adults (LADA), with differentials being late-onset Type 1 Diabetes Mellitus and autoimmune polyglandular syndrome. Treatment was revised to basal-bolus insulin. HbA1c improved to 11.6% within one year.

CASE 2
A 33-year-old female, obese (BMI 28 kg/m^2), with features of insulin resistance and diabetic parents, was admitted for DKA. – Laboratory results were as follows: RBS 31 mmol/L, serum ketone 5.3 mmol/L, pH 7.23, HCO3 14. Baseline HbA1c was 17.1%. She was started on subcutaneous insulin isophane) 34 units, T, Metformin XR 2 g ON and T and Vildagliptin 50 mg BD (DPP-4i) and was discharged with these medications. Self-monitoring blood glucose after two weeks was unsatisfactory. Results revealed normal C-peptide of 470 pmol/L (367-1467 pmol/L), negative IA2: <2.5 IU/ml (<28 IU/ml), positive ICA: 157IU/ml (>28 IU/ml) and GAD: >280 IU/ml (>17 IU/ml). Maturity-onset diabetes of the young (MODY) was considered. Adding sulfonylureas resulted in suboptimal glycaemic control. HbA1c improved to 14.6% within one year after switching to premixed insulin.

CONCLUSION
Subclassifying diabetic patients with positive diabetes-associated autoantibodies necessitates a comprehensive approach, considering family history, phenotype and targeted genetic testing.