

REVIEW

[View Article Online](#)
[View Journal](#) | [View Issue](#)
Cite this: *Food Funct.*, 2025, **16**, 2622Received 4th December 2024,
Accepted 4th March 2025

DOI: 10.1039/d4fo06011c

rsc.li/food-function

Dietary therapy to halt the progression of diabetes to diabetic kidney disease†

Hongtu Hu,^{a,b} Guohua Ding^{*a,b} and Wei Liang ^{*a,b}

Diabetic Kidney Disease (DKD) is a common and serious complication of diabetes, particularly Type 2 Diabetes Mellitus (T2DM), which significantly contributes to patient morbidity and mortality. The limitations of traditional treatments like ACE inhibitors and ARBs in managing DKD progression highlight the need for innovative therapeutic strategies. This review examines the impact of various dietary patterns, such as the Mediterranean diet, ketogenic diet, intermittent fasting, DASH diet, and vegetarian diet, on the management of DKD. Evidence suggests these diets can halt the progression of DKD, although further research is needed to confirm their long-term effectiveness and safety. Personalized dietary approaches tailored to individual needs may enhance outcomes for DKD patients.

1 Introduction

Over the past century, non-communicable diseases (NCDs),¹ including cardiovascular disease, cancer, and diabetes,² have emerged as the leading causes of mortality and morbidity worldwide. Among these, diabetes, particularly Type 2 Diabetes Mellitus (T2DM), has become an epidemic, contributing significantly to the global healthcare burden.³ Diabetic Kidney Disease (DKD) is a common and severe complication of T2DM, characterized by progressive kidney damage that increases the risk of kidney failure and premature death. DKD is not only a major cause of end-stage renal disease (ESRD), but it also exacerbates the comorbidities associated with diabetes, such as cardiovascular diseases, creating a vicious cycle of deterioration in patient health and quality of life.⁴

Despite advancements in treatment options, conventional therapies, such as Angiotensin-Converting Enzyme (ACE) inhibitors and Angiotensin II Receptor Blockers (ARBs), have shown limited efficacy in halting or reversing the progression of DKD. These therapies primarily aim to control blood pressure and proteinuria but do not address the root causes or mitigate the long-term impacts of DKD progression. As a result, there remains a critical gap in effective treatments that can prevent the worsening of kidney function in diabetic patients.

Emerging evidence suggests that dietary interventions may offer a promising alternative or adjunct to pharmacological treatments in managing DKD. While various dietary patterns,

including the Mediterranean diet, ketogenic diet, intermittent fasting, Dietary Approaches to Stop Hypertension (DASH) diet, and vegetarian diet, have been explored for their potential benefits in managing DKD, the evidence is still inconclusive, particularly regarding their long-term efficacy, safety, and mechanisms of action. This highlights a significant research gap in understanding how different dietary patterns affect DKD progression, and whether these dietary approaches can provide sustained benefits over time. Therefore, this review aims to critically evaluate the current state of knowledge on dietary therapies for DKD, examining their potential to improve patient outcomes and slow disease progression, while identifying areas where further research is urgently needed.

2 Literature search method

To identify relevant studies, we screened publications to date that discussed dietary therapies, such as Mediterranean diet, Ketogenic Diet, and DASH diet, and their role in preventing the progression of diabetes to DKD. We conducted searches in databases including Elsevier, Wiley, Taylor, Francis Online, and Web of Science using keywords such as “diabetes”, “diabetic kidney disease”, “Mediterranean diet”, “Ketogenic Diet”, “fasting”, “Ketogenic Diet”, “DASH diet” and “vegetarian diet”. A total of 281 articles were identified, of which 133 were actually cited.

3 T2DM and diet

Diabetes mellitus (DM) is a prevalent group of NCDs, with over 500 million individuals affected globally, and more than 90%

^aDivision of Nephrology, Renmin Hospital of Wuhan University, Wuhan, China.E-mail: ghxding@whu.edu.cn, dr.liangwei@whu.edu.cn^bNephrology and Urology Research Institute of Wuhan University, Wuhan, China†Electronic supplementary information (ESI) available. See DOI: <https://doi.org/10.1039/d4fo06011c>

of these cases are T2DM.⁵ It is well established that weight gain and obesity are associated with the development of T2DM. Additionally, the development of T2DM is accompanied by obesity and insulin resistance, primarily due to the phosphorylation of the insulin receptor substrate (IRS) by receptor tyrosine kinases (RTK), which further contributes to elevated glycemia. Both factors are directly related to food intake.³

The etiology of T2DM remains complex and not fully understood. However, evidence indicates that T2DM is characterized by pathophysiological changes, including pancreatic β -cell dysfunction, insulin resistance, and chronic inflammation, which collectively impede glycemic control.⁶ Furthermore, T2DM promotes increased cellular and chemokine levels, such as TNF- α and IL-6, and activates pro-fibrotic signaling pathways, including TGF- β and NF- κ B, ultimately leading to complications.⁷

Recent studies have highlighted that an unhealthy diet significantly contributes to T2DM development.⁸ Diets high in calories, fat, and sugar are associated with weight gain and

obesity, particularly central obesity (abdominal fat accumulation), leading to reduced insulin sensitivity and the development of insulin resistance. This impairs the entry of blood glucose into cells for energy production, resulting in elevated blood glucose levels and the onset of T2DM.⁹ Additionally, a diet high in fat, particularly saturated fatty acids, has been linked to fat accumulation in visceral organs, such as the liver. This ectopic fat accumulation interferes with insulin signaling, leading to chronic inflammation, insulin resistance, and elevated blood glucose levels.¹⁰

In addition, diet significantly influences the composition and functionality of the gut microbiome. Disturbed gut microbes have been linked to exacerbated metabolic disorders and chronic inflammation, reducing insulin sensitivity.¹¹ Therefore, dietary habits play a crucial role in T2DM development. Diets high in calories, fat, and sugar increase the risk of T2DM (Fig. 1). Consequently, adopting a healthy and balanced dietary structure and appropriate nutritional management is paramount in preventing and controlling T2DM.

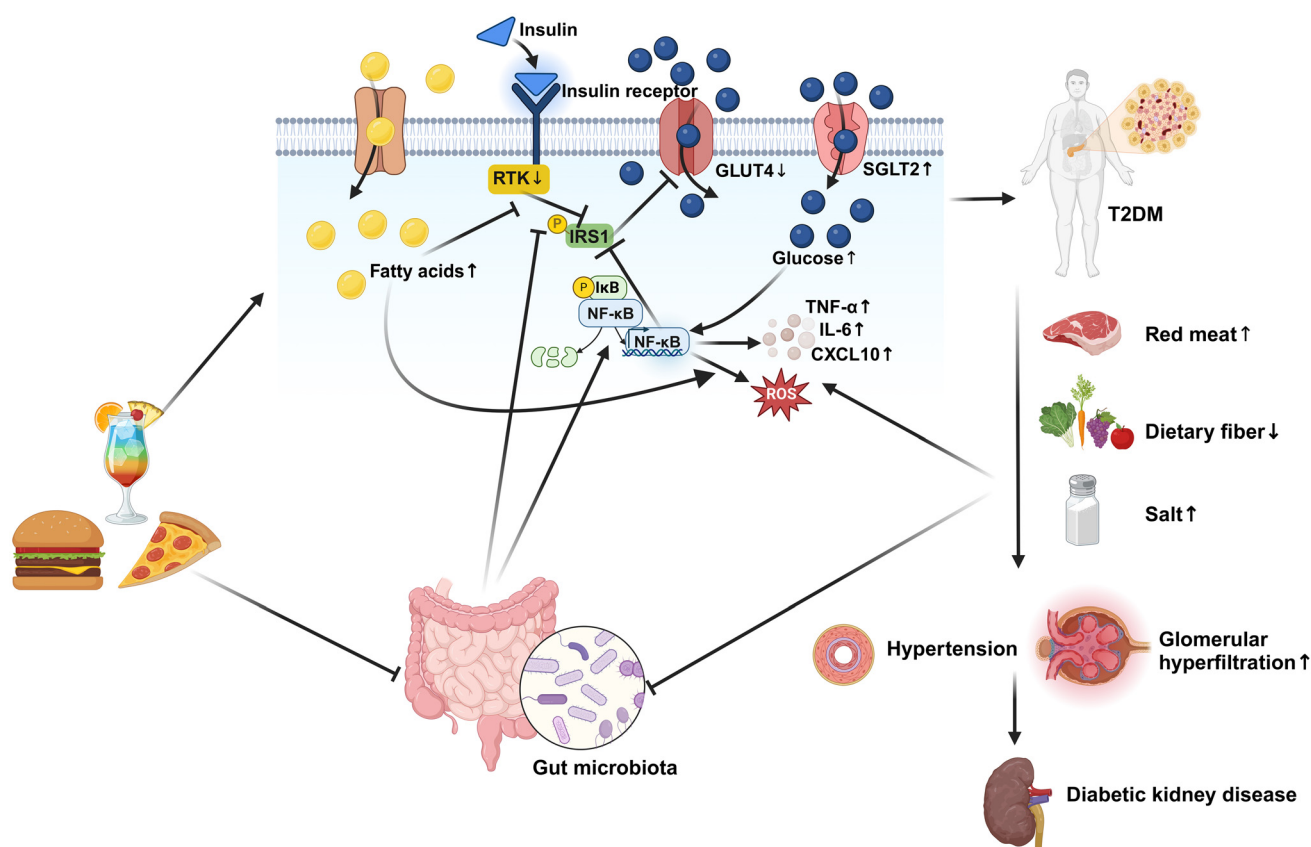


Fig. 1 The role of diet in type 2 diabetes (T2DM) and diabetic kidney disease (DKD). A high-calorie, high-fat, and high-sugar diet is linked to weight gain and central obesity, disrupting insulin signaling, triggering chronic inflammation, and causing insulin resistance. This diet also alters gut microbiota, leading to metabolic disorders and reduced insulin sensitivity, ultimately causing type 2 diabetes (T2DM). In T2DM patients, continued intake of such a diet elevates blood glucose, damages glomerular filtration membranes, and accelerates diabetic kidney disease (DKD). Western diets high in salt and fat increase hypertension risk, worsening glomerular damage and promoting DKD. Excessive red and processed meat consumption burdens kidneys, accelerating dysfunction, while moderate vegetable protein intake offers protection. Low dietary fiber disrupts gut flora, leading to metabolic disorders and inflammation, accelerating DKD. Created with BioRender.com.



4 Diabetic kidney disease (DKD)

As T2DM progresses, an unhealthy diet significantly contributes to the progression of diabetic disease and has been linked to adverse effects on multiple organs, including the heart, retina, liver, and kidneys.¹² DKD is one of the most prevalent and severe complications of diabetes, significantly increasing patient mortality.⁴ The role of diet in the progression of T2DM to DKD is complex and multifactorial. A high-glucose, high-fat diet in T2DM patients leads to elevated blood glucose levels, exacerbating insulin resistance and ultimately causing a chronic hyperglycemic state. Persistent hyperglycemia damages the glomerular filtration membrane, leading to glomerular hyperfiltration and accelerating DKD onset and development.

The Western diet, characterized by high salt and fat intake, significantly increases hypertension incidence, exacerbating glomerular damage and promoting DKD development.¹³ Excessive consumption of animal protein, particularly red and processed meat, may strain the kidneys and hasten renal function deterioration.¹⁴ Conversely, moderate plant protein intake may protect the kidneys.^{15,16} Inadequate dietary fiber consumption may disrupt intestinal flora equilibrium, leading to metabolic imbalances and inflammatory responses, impeding DKD progression (Fig. 1).¹⁷

In DKD, the kidneys undergo structural and functional alterations, impairing glomerular filtration and tubular reabsorption due to glomerulosclerosis and interstitial fibrosis. The renal damage caused by DKD is irreversible, contributing to disease progression and ultimately leading to end-stage renal disease (ESRD).¹⁸ Current therapeutic strategies, primarily supportive, involve using angiotensin-converting enzyme inhibitors (ACEIs) and angiotensin II receptor antagonists (ARBs) but have not reversed DKD progression. Thus, there is an urgent need for new therapeutic tools to address this unmet clinical need.¹⁹

Dietary control is a common and critical treatment strategy for DKD patients. Recent studies have shown that dietary intervention can significantly slow DKD progression.²⁰ The most commonly prescribed dietary patterns include the Mediterranean, ketogenic, fasting, and DASH diet.²¹ These dietary patterns emphasize different food intake priorities and have demonstrated therapeutic potential in DKD management. However, it remains unclear whether food consumption within different dietary patterns affects the efficacy of nutritional supplementation, potentially accelerating disease progression in DKD patients, particularly given the chronic nature of the disease. Therefore, examining the relationship between diet and T2DM and DKD is vital, providing a comprehensive overview of different dietary therapies in DKD and significant advances in understanding the underlying mechanisms. By discussing this topic, we can enhance strategies for preventing and treating DKD and improve DKD prognosis through dietary interventions.

5 Role of dietary therapy in DKD

5.1 DKD and mediterranean diet (MED)

The traditional MED originates from the coastal areas of the Mediterranean Sea and is characterized by high consumption of vegetables, fruits, nuts, and olive oil.²² The MED has garnered considerable research interest in recent years due to its potential to prevent various chronic diseases, including cardiovascular disease, T2DM, metabolic syndrome, certain cancers, and chronic kidney disease.^{23,24} A *meta*-analysis of 2 217 404 participants showed that adherence to the MED significantly reduces the risk of developing colorectal cancer.²⁵ Another *meta*-analysis demonstrated that the MED reduces liver enzymes and liver fat content in patients with non-alcoholic fatty liver disease (NAFLD).²⁶ Additionally, recent studies have associated the MED with notable improvements in overall cognition and gastrointestinal symptoms.²⁷

In diabetes treatment, the MED has yielded noteworthy outcomes. Prospective studies have shown that adherence to the MED is associated with a reduced risk of developing diabetes,^{28,29} and significant reductions in glycated hemoglobin levels³⁰ and inflammation³¹ in patients with prediabetes and T2DM. Furthermore, the MED has been shown to diminish the incidence of cardiovascular complications,³² carotid atherosclerosis,³³ non-alcoholic fatty liver disease,³⁴ and mortality in patients with T2DM.³⁵ A recent *post-hoc* analysis from the San Carlos Gestational Prevention Study demonstrated that a nutritional regimen based on the MED before the twelfth week of gestation reduces the incidence of gestational diabetes mellitus at three years postpartum.³⁶ Moreover, a prospective cohort study found that the MED significantly reduces the risk of DKD in patients with hyperglycemia,³⁷ with a dose-dependent effect.³⁸ However, adding extra virgin olive oil to the MED does not prevent DKD in the cohort study.³⁹ Numerous studies have also substantiated that adherence to the MED is not markedly correlated with cardiovascular risk factors and renal function.^{40,41}

From a mechanical perspective, the components of the MED are effective in reversing the progression of T2DM to DKD. The abundance of antioxidants, such as ascorbic acid and β -carotene in MED foods significantly reduces oxidative stress, chronic inflammation, and platelet aggregation.^{42,43} Furthermore, adherence to the MED has been linked to lower levels of C-reactive protein (CRP),⁴⁴ which correlates with a reduced impact of elevated blood glucose on renal cellular function, thus lowering the risk of developing DKD from T2DM. Recent clinical studies have demonstrated that glucagon-like peptide-1 (GLP-1) can attenuate the progression of T2DM⁴⁵ and DKD⁴⁶ by promoting insulin production and secretion. Notably, the MED has been shown to promote GLP-1 secretion,⁴⁷ enhance endothelial function, and delay DKD progression in T2DM patients.⁴⁸

Moreover, evidence indicates that the MED can correct the imbalance of gut microbial homeostasis in patients with T2DM and DKD.⁴⁹ Gut microbes utilize the fiber in the MED to synthesize short-chain fatty acids (SCFAs),⁵⁰ which regulate



glucose and lipid metabolism,⁵¹ slowing the progression of T2DM. While the MED emphasizes whole plant foods, excessive consumption of refined carbohydrates (*e.g.*, fruit juices, processed grains) within some MED interpretations may paradoxically elevate insulin resistance risk (Fig. 2).⁵² Additionally, individuals with T2DM adhering to the MED may risk protein malnutrition.⁵³ Therefore, further clinical trials are required to fully understand the benefits and risks of MED in T2DM and DKD.

5.2 DKD and ketogenic diet (KD)

The ketogenic diet (KD) was initially developed in the 1920s and gained popularity for treating epilepsy in children. By mimicking the fasting state (*i.e.*, reducing carbohydrates and increasing fat intake), it effectively reduces the frequency of seizures. However, its use declined with the advent and development of antiepileptic drugs. In recent years, the KD has received attention for its potential benefits beyond epilepsy, including weight loss, T2DM, metabolic syndrome, and other neurological disorders such as Alzheimer's and Parkinson's diseases.⁵⁴

The KD is a high-fat, low-carbohydrate, and moderate-protein diet.⁵⁵ It induces a metabolic state called ketosis, characterized by reduced carbohydrate intake and increased fat intake. In this state, the body primarily relies on fats and ketone bodies (produced by the liver) for energy rather than glucose.⁵⁶ Since its introduction, the KD has demonstrated benefits such as extending life expectancy,⁵⁷ enhancing memory,⁵⁸ improving tumor prognosis,⁵⁹ facilitating liver metabolism,⁶⁰ and inhibiting the progression of polycystic kidney disease.⁶¹

Similarly, the KD plays an important role in treating T2DM. The KD has been shown to prevent the development of obesity and diabetes⁶² and to significantly affect blood glucose levels and insulin sensitivity, reducing glycated hemoglobin levels³⁰ and body weight⁶³ in patients with T2DM. A recent 12-week randomized controlled study analyzed 60 overweight patients with newly diagnosed diabetes, comparing a conventional diabetic diet (30 subjects) with a ketogenic diet (30 subjects). The results demonstrated that the KD significantly improved glycated hemoglobin, fasting blood glucose, insulin levels, lipids, weight, and body mass index (BMI).⁶⁴ Another recent randomized controlled trial (RCT) (NCT03810378) compared the effects of a ketogenic diet and a low-carbohydrate Mediterranean diet on glycemic and cardiometabolic risk factors in patients with type 2 diabetes or pre-diabetes. The results showed that both diets positively affected glycated hemoglobin, but the KD was more effective in lowering triglycerides and body weight and increasing HDL cholesterol.³⁰

Typically, the body obtains energy from glucose in carbohydrates. In contrast, the KD emphasizes strict carbohydrate restriction, significantly reducing intestinal monosaccharide absorption and thus lowering blood glucose levels.⁶⁵ Additionally, the KD regulates hepatic glycogen breakdown, affecting basal glucose metabolism and reducing blood glucose levels.^{66,67} The KD also alters the gut microbiome com-

position, increasing the proportion of anabolic bacteria, promoting digestive processes, and facilitating weight loss.⁶⁸ Moreover, the KD influences gut microbes to produce short-chain fatty acids, which regulate blood glucose, stimulate GLP-1 secretion,⁵¹ and alleviate insulin resistance.⁶⁹ The KD has also demonstrated anti-inflammatory,⁷⁰ anti-hepatic fibrosis,⁷¹ antioxidant,⁷² and mitochondrial function effects (Fig. 2).⁷³ Additionally, studies observed that patients could significantly reduce or discontinue their diabetes medications during KD treatment.⁷⁴

This evidence collectively indicates that the KD can markedly impede the progression of T2DM to DKD. However, the role of the KD in DKD development remains debated in the scientific community. Animal studies have provided compelling evidence that the KD can effectively reverse mitochondrial energy metabolism,⁷⁵ proteinuria,⁷⁶ and oxidative stress⁷⁷ in animal models of T2DM (db/db mice). Furthermore, clinical studies have substantiated that the KD enhances glomerular filtration indexes, diabetic status, and risk factors for kidney disease progression in DKD patients.⁷⁸ Currently, there is limited direct research on the KD and DKD.

It is important to note that not all observed beneficial effects are attributable to the KD; some effects are associated with overall carbohydrate intake rather than ketosis. A high protein intake may also increase renal burden, particularly in patients with pre-existing renal impairment.⁷⁹ Although the KD emphasizes fat intake, protein intake may increase in practice.⁸⁰ The KD may initially cause electrolyte imbalances, including potassium, sodium, and magnesium, which are particularly important in patients with renal insufficiency.⁸¹ Furthermore, the KD carries the risk of triggering ketoacidosis, a life-threatening condition.⁸²

Given the potential benefits and risks associated with KD in managing DKD, its implementation must be undertaken with caution and under the guidance of medical professionals and dietitians. Additional clinical studies and long-term follow-up data will clarify the efficacy and safety of KD in managing DKD.

5.3 DKD and fasting

Fasting has recently gained considerable attention as a potential strategy for managing health and disease. Fasting is the complete abstinence from food or a significant reduction in calorie intake over a specified period. The fundamental premise is to induce a shift in the body's metabolic state by temporarily reducing or halting food intake to achieve health benefits. The principal categories of fasting include intermittent fasting, exemplified by the 16 : 8 diet (eating and drinking are limited to 8 hours of the day and fasting for the remaining 16 hours), the 5 : 2 diet (5 days of a normal diet and 2 days of a low-calorie diet), alternate-day fasting, 24-hour fasting, extended fasting (fasting for more than 24 hours, usually ranging from 48 hours to several days), and time-restricted diets (eating is limited to a certain window of time each day, usually 8–12 hours).⁸³ Fasting is typically considered safe and has significantly prevented disease progression.⁸⁴



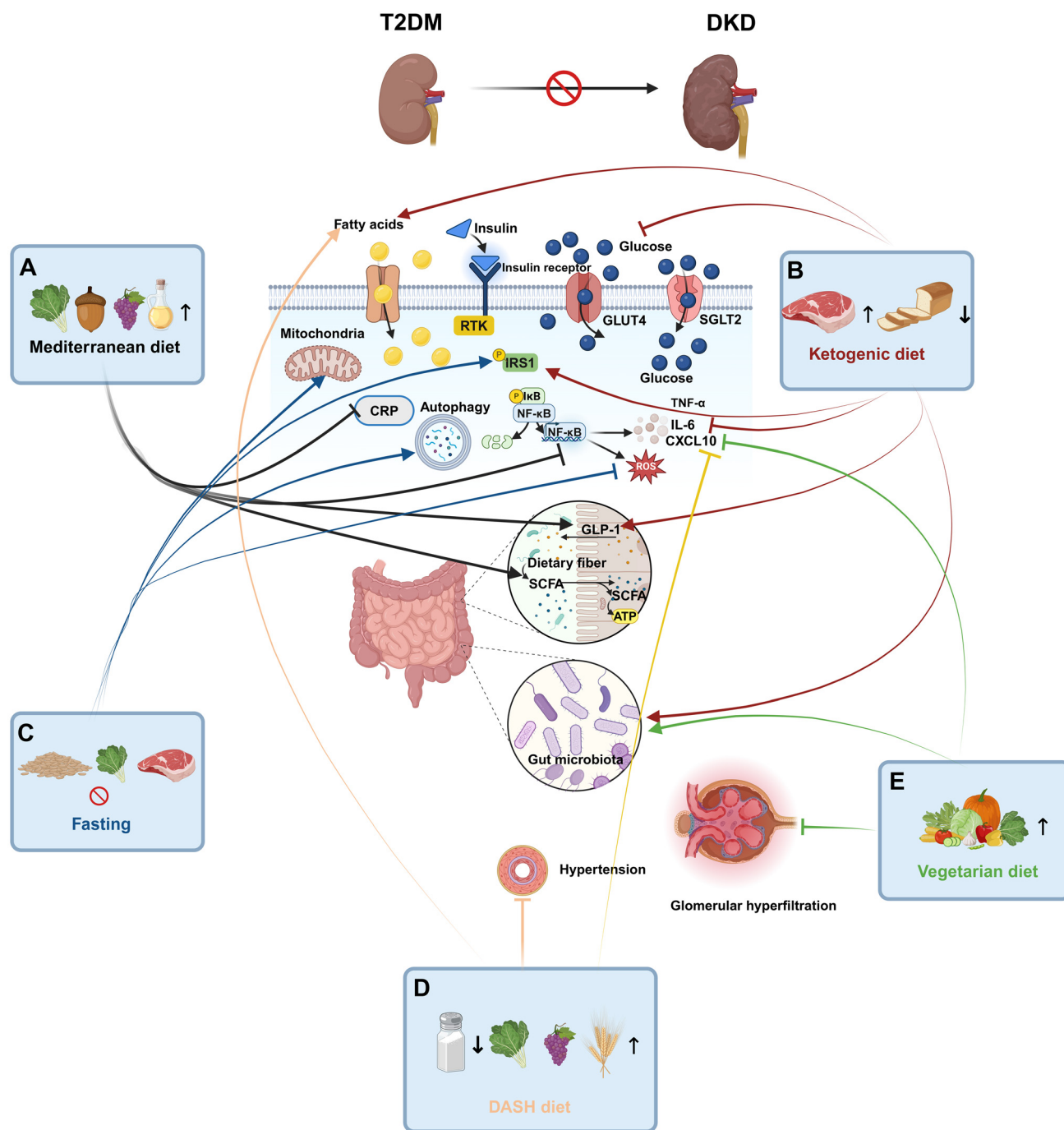


Fig. 2 Molecular mechanisms of dietary therapy and their metabolites in diabetic kidney disease. (A) The Mediterranean diet (MED) has been demonstrated to impede the progression of Type 2 diabetes mellitus (T2DM) to diabetic kidney disease (DKD) through the reduction of inflammatory responses and oxidative stress, the stimulation of glucagon-like peptide 1 (GLP-1) secretion, and the modulation of the gut microbiota. (B) The ketogenic diet (KD) has been demonstrated to impede the progression of T2DM to DKD through the regulation of the body's metabolic state, the influence of gut microbiota homeostasis, the promotion of GLP-1 secretion, and the exertion of anti-inflammatory and antioxidant effects. (C) Fasting has been demonstrated to delay renal cell damage and loss of function. This is achieved by improving insulin sensitivity, reducing inflammation and oxidative stress, and promoting mitochondrial function and autophagy processes. (D) The DASH diet has been demonstrated to safeguard kidney function by regulating blood pressure and reducing inflammation, lipid levels and kidney burden. (E) The vegetarian diet has been demonstrated to impede the progression of T2DM to DKD through a number of mechanisms. These include antioxidant and anti-inflammatory effects, modulation of gut microbiota, reduction of proteinuria and improved nutritional status. Created with BioRender.com.



Animal studies have confirmed that 5:2 or 16:8 intermittent fasting improves non-alcoholic steatohepatitis (NASH) and its transition to hepatocellular carcinoma (HCC),^{85,86} and reduces body weight.⁸⁷ Fasting has also been demonstrated to slow the aging process,^{88,89} reduce blood pressure and cardiovascular risk, and lower blood pressure and cardiovascular risk.^{90,91} Furthermore, fasting plays a significant role in managing T2DM. Intermittent fasting has been shown to significantly reduce body weight,⁹² improve lipid and glucose metabolism,⁹³ and reduce inflammatory and oxidative stress levels in patients with T2DM (Fig. 2).⁹⁴ A recent RCT (ChiCTR2000040656) of Chinese adults with early-stage type 2 diabetes found that the 5:2 diet reduced body weight and blood glucose levels in the short term compared to metformin or empagliflozin. These findings suggest that the 5:2 diet may be a promising approach for the initial intervention and early management of T2DM.⁹⁵ Furthermore, a fasting protocol alleviated gut microbial disorders and prevented complications in db/db mice.⁹⁶ Animal studies demonstrate that fasting remodels mitochondrial networks, though human data remain limited.⁹⁷

Nevertheless, the potential benefits of fasting in the context of DKD warrant further investigation. Currently, there is a lack of conclusive evidence from clinical and animal studies confirming the role of fasting in the progression of T2DM to DKD and the progression of DKD itself. However, based on the available evidence, it can be hypothesized that fasting may have a beneficial impact on the progression of T2DM to DKD by enhancing mitochondrial function in renal tubular cells,⁹⁸ promoting mitophagy,⁹⁹ and promoting ketone body production,¹⁰⁰ among other mechanisms to exert renoprotective effects.

Given the unique and complex nature of DKD, prolonged fasting may potentially lead to malnutrition and further increase the renal burden in patients with DKD. Therefore, it is essential to exercise caution when implementing fasting. One potential approach could be to gradually extend the duration of fasting and ensure adequate intake of essential nutrients, including vitamins, minerals, and dietary fiber, during the feeding period. Furthermore, additional clinical studies and long-term follow-up data will undoubtedly contribute to a better understanding of the effectiveness and safety of fasting in managing DKD.

5.4 DKD and DASH diet

The National Heart, Lung, and Blood Institute (NHLBI) developed the DASH diet with the original intention of helping individuals reduce high blood pressure. Additionally, it is a dietary pattern conducive to promoting overall health. The DASH diet is rich in fruits, vegetables, and low-fat dairy products and includes whole grains and legumes. It emphasizes nutrient-rich foods that have been shown to benefit blood pressure, such as potassium, calcium, and magnesium while encouraging the limitation of sodium, saturated fats, and sugar intake.¹⁰¹

The DASH diet has demonstrated considerable success in managing hypertension. A recent randomized controlled trial (RCT) (IRCT20180201038585N12) involving 60 subjects with

metabolic syndrome showed that the DASH diet effectively managed hypertension.¹⁰² Another RCT (ChiCTR2300069393) found that combining an 8-hour time-limited diet with the DASH diet resulted in a more pronounced reduction in blood pressure compared to DASH alone in stage 1 hypertension patients.¹⁰³ Mechanistically, the DASH diet controls blood pressure by increasing potassium and sodium intake. The increased dietary fiber in the DASH diet indirectly controls blood pressure by lowering cholesterol, thereby slowing the progression of hypertension and cardiovascular events.^{101,104}

Furthermore, the DASH diet has been demonstrated to reduce the risk of chronic kidney disease (CKD).¹⁰⁵ Recent studies have shown that the DASH diet is associated with a reduced risk of developing T2DM,¹⁰⁶ increased insulin sensitivity,¹⁰⁷ and better control of blood pressure¹⁰⁸ and body weight¹⁰⁹ in T2DM patients (Fig. 2). The DASH diet's low protein intake and antioxidant-rich foods (e.g., vegetables and fruits) reduce kidney burden¹¹⁰ and decrease the inflammatory response.¹¹¹ Additionally, the DASH diet helps reduce LDL cholesterol and triglycerides while increasing HDL cholesterol, safeguarding the cardiovascular system and, indirectly, the kidneys.¹¹² Recent clinical studies also corroborate that the DASH diet mitigates the likelihood of progression to DKD in T2DM patients.^{38,113}

In conclusion, the DASH diet represents a scientifically backed and effective dietary pattern particularly suited to preventing and controlling hypertension. Moreover, it effectively inhibits the progression of T2DM to DKD and promotes overall health. However, it is important to note that although the DASH diet recommends lean meat and fish, patients with kidney disease may require further protein intake reduction. Due to impaired renal function, DKD patients must also restrict foods rich in potassium and phosphorus. Despite the DASH diet's emphasis on fruits and vegetables, adjustments may be necessary due to the potassium content of these foods. Additionally, while the DASH diet is inherently low in sodium, DKD patients must rigorously monitor their sodium intake to prevent hypertension and fluid retention.

Overall, implementing the DASH diet requires a gradual transition and long-term adherence. For optimal results, it is recommended that this diet be followed under the guidance of a healthcare professional.

5.5 DKD and vegetarian diet

A vegetarian diet is based on plant-based foods, excluding all animal products, including red and white meat and fish. The classification of vegetarian diets includes strict vegetarian, egg-lacto-vegetarian, lacto-vegetarian, egg-vegetarian, and fish-vegetarian diets.¹¹⁴ Prospective epidemiological studies indicate that a vegetarian diet may have a preventive effect against obesity,¹¹⁵ hypertension,¹¹⁶ cancer,¹¹⁷ and cognitive decline.¹¹⁸ A recent meta-analysis indicates that adherence to a plant-based diet for a minimum of 14 days is associated with improved insulin resistance in individuals with a BMI above the healthy range.¹¹⁹ Furthermore, a vegetarian diet has been demonstrated to diminish the likelihood of developing T2DM.¹²⁰



Recent animal studies have suggested that a vegetarian diet may impede the progression of T2DM to DKD by enhancing insulin sensitivity,¹²¹ preventing oxidative stress, and reducing inflammation (Fig. 2).¹²² Recent clinical studies have also demonstrated that vegetarian diet plant proteins significantly reduce CKD risk in diabetic patients compared to animal proteins.¹²³ These diets have been shown to significantly reduce albuminuria and improve nutritional status in patients with DKD.¹²⁴

It is important to note that patients with DKD must control their protein intake while ensuring sufficient high-quality plant protein intake. Additionally, certain plant foods are high in phosphorus and potassium, and intake must be monitored according to renal function to prevent the accumulation of these minerals in the body.

In conclusion, a vegetarian diet may benefit individuals with DKD, but it must be planned and managed appropriately to ensure adequate nutritional intake and avoid potential risks.

6 Comparison of different dietary therapies in DKD

Dietary therapies represent a pivotal intervention in the management of DKD. The complex relationship between diet and the progression of DKD indicates that no single dietary approach can exert optimal therapeutic effects on its own (Fig. S1†). Instead, a multifaceted approach may be required to address the various metabolic demands and complications associated with DKD.

Each dietary strategy has distinctive benefits and mechanisms of action. The Mediterranean diet (MED) is characterized by a high content of antioxidants and anti-inflammatory components, which may contribute to reducing oxidative stress and chronic inflammation, both considered key factors in the progression of DKD. The vegetarian and DASH diets emphasize the consumption of fruits and vegetables and the reduction of sodium intake, demonstrating efficacy in managing blood pressure and overall cardiovascular health. Additionally, these diets confer indirect benefits to kidney function.

Although there is evidence that ketogenic diets (KD) and intermittent fasting regimens may provide metabolic benefits, such as improved insulin sensitivity and reduced oxidative stress essential for managing DKD, it is unclear to what extent fasting can slow the progression of DKD in T2DM patients. Furthermore, ensuring that patients with diet-restricted DKD consume adequate amounts of essential nutrients (*e.g.*, proteins, vitamins, and minerals) remains challenging. The inherent risks associated with KD and fasting, such as electrolyte imbalances, ketoacidosis from KD, and nutritional deficiencies from prolonged fasting, necessitate close monitoring and professional guidance.

Different dietary patterns exhibit varying degrees of risk. In MED, the consumption of certain foods, such as full-fat

cheeses and proteins, may require individual adjustments.¹²⁵ KD, high in saturated fat, increases the risk of cardiovascular disease, and its long-term effects on renal function are unclear, necessitating caution in patients with pre-existing renal impairment.¹²⁶ The DASH diet's high potassium intake may be risky for patients with impaired renal function and requires individualized adjustment.¹²⁷ Fasting diets may result in nutritional imbalances and glycemic fluctuations, particularly in insulin-dependent patients, necessitating caution and professional guidance.¹²⁸ Vegetarian diets must ensure sufficient plant protein intake and micronutrient supplementation, such as vitamin B12, iron, and calcium, to prevent nutritional deficiencies.¹²⁹

Implementing these dietary patterns in managing DKD must consider the individual's health status, nutritional requirements, and personal preferences (Table 1). Therefore, it is recommended that dietary plans be developed under the guidance of healthcare professionals to ensure the safety and efficacy of the dietary regimen. Several clinical trials (NCT05495451, NCT05984459, NCT05589467, and NCT06152588) aim to improve outcomes for T2DM or DKD patients by combining dietary therapy (Table S1†).

7 Current challenges and future directions

7.1 Limitations and challenges

7.1.1 Complexity of dietary interventions. One of the primary challenges is the complexity of dietary interventions and their varying impacts on individuals with DKD. While the Mediterranean diet, DASH diet, and ketogenic diet, among others, have demonstrated potential benefits, individual responses can vary considerably due to genetic susceptibility, coexisting conditions, and lifestyle choices. This variation complicates the development of universal dietary guidelines and necessitates a more individualized approach.

7.1.2 Adherence and sustainability. Long-term adherence to prescribed dietary therapies represents a significant challenge. Many patients encounter difficulties adhering to dietary changes over the long term due to cultural preferences, socioeconomic factors, or a lack of understanding of the diet's benefits. Ensuring the sustainability of these dietary interventions requires implementing strategies to enhance patient education and support.

7.1.3 Lack of comprehensive guidelines. The absence of standardized dietary guidelines specific to DKD represents a significant challenge. Current recommendations frequently vary by healthcare provider, resulting in inconsistent dietary advice. This inconsistency can cause patient concern and reduce the effectiveness of dietary interventions.

7.1.4 Integration with medication. It is imperative to enhance the integration of dietary therapies with existing pharmacological treatments for DKD. While certain dietary components may augment medication efficacy, others may impede drug metabolism or exacerbate adverse effects. A com-



Table 1 Comparison of different dietary therapies in DKD

Dietary pattern	Advantages	Disadvantages	Research conclusions
Mediterranean diet	Rich in healthy fats (olive oil), antioxidants (fruits and vegetables), and fiber (whole grains); associated with reduced inflammation, improved glycemic control, and cardiovascular health benefits. ^{7,31–43}	May be difficult to adhere to in the long term due to dietary restrictions and availability of specific foods; can be more expensive compared to standard diets. ^{60,61,133}	Shows potential in reducing the risk of DKD progression, improving glycemic control, reducing cardiovascular risk, and enhancing overall health outcomes. Widely supported by numerous studies. ^{31–43}
Ketogenic diet	Low carbohydrate intake forces the body to use fat as a primary energy source, which can improve glycemic control, promote weight loss, and potentially improve insulin sensitivity. ^{38,62–71}	May lead to nutrient deficiencies (fiber, vitamins, and minerals) and is not suitable for everyone, especially those with kidney issues due to the high protein and fat content. ^{88–90}	Mixed results; some studies show benefits in weight loss and glycemic control, while others highlight potential risks, especially for kidney health. Long-term safety and effects need further research. ^{38,62–71}
Fasting	Flexible approach with various fasting schedules; can promote weight loss, improve insulin sensitivity, and reduce oxidative stress and inflammation. ^{91–105}	Can be difficult to maintain; potential for overeating during feeding periods, which might negate the benefits; initial adaptation phase can be challenging.	Emerging evidence suggests benefits for metabolic health, weight loss, and reduction in inflammation and oxidative stress. Long-term effects and optimal fasting protocols require further investigation. ^{91–105}
DASH diet	Emphasizes fruits, vegetables, whole grains, and low-fat dairy; associated with lower blood pressure, improved heart health, reduced risk of cardiovascular diseases, and better glycemic control. ^{109–121}	May be difficult to adhere to due to dietary restrictions and the need for significant changes in eating habits; requires careful planning to meet nutritional needs. ¹²¹	Associated with improved kidney function, lower blood pressure, and reduced cardiovascular risk. Adherence can be challenging, but the health benefits are well-supported by research. ^{109–121}
Vegetarian diet	High in fiber (fruits, vegetables, legumes) and low in saturated fats; associated with reduced risk of chronic diseases (heart disease, hypertension), improved kidney function, and potential weight management benefits. ^{122–132}	Requires careful planning to ensure adequate nutrient intake, especially protein, vitamin B12, iron, and omega-3 fatty acids; potential for nutrient deficiencies if not well-planned.	Generally beneficial for kidney function and overall health; reduces risk of chronic diseases and supports weight management. Nutrient deficiencies need to be managed through careful dietary planning. ^{122–132}

prehensive understanding of these interactions is essential to optimize treatment regimens.

7.1.5 Impact of comorbidities. A significant proportion of individuals with DKD also present with comorbidities such as cardiovascular disease or hypertension. This necessitates considering additional dietary factors. Managing DKD through diet is further complicated by the need to balance the dietary demands of multiple conditions.

7.2 Strategies to overcome challenges and improve clinical translation

7.2.1 Personalized nutrition. Advances in nutrigenomics and metabolomics offer the potential for developing personalized nutrition plans based on an individual's genetic and metabolic profile. By understanding how specific nutrients interact with a patient's unique biological makeup, healthcare providers can design more effective dietary interventions.

7.2.2 Long-term clinical trials. Large-scale, long-term clinical trials are imperative to assess the efficacy and safety of various dietary patterns in treating DKD. These studies must encompass diverse populations to account for genetic and environmental differences and aim to elucidate the mechanisms by which diet affects kidney function.

7.2.3 Role of the gut microbiota. Recent studies have demonstrated that the gut microbiota plays a pivotal role in mediating the effects of dietary interventions in DKD. The underlying mechanism involves multifaceted interactions, including the production of short-chain fatty acids (SCFAs,

e.g., butyric acid, propionic acid) by GM fermentation of dietary fiber. These SCFAs have been shown to reduce renal inflammation and maintain intestinal barrier integrity by inhibiting histone deacetylase (HDAC) and activating G-protein-coupled receptors (e.g., GPR43/41), which can reduce the intestinal-derived accumulation of uremic toxins (e.g., indophenol sulphate, paracresol) and alleviate renal tubulointerstitial fibrosis.¹³⁰ Secondly, intestinal-derived lipopolysaccharide (LPS) translocation caused by GM dysregulation can activate the Toll-like receptor 4 (TLR4) signaling pathway, promote the release of inflammatory factors (e.g., IL-6, TNF- α) from glomerular mesangial cells, and accelerate the progression of DKD.¹³¹ Clinical studies have further revealed a direct association between GM composition and renal function indices. A cohort study of 432 DM patients found that the relative abundance of butyric acid-producing bacteria in the gut (e.g., *Faecalibacterium prausnitzii*, *Roseburia* spp.) was positively correlated with estimated glomerular filtration rate (eGFR) ($\beta = 0.34$, $P < 0.01$). Furthermore, the annual rate of decline in eGFR increased by 0.82 mL min^{-1} per 1.73 m^2 for each log unit decrease in its abundance.¹³² Furthermore, elevated levels of the GM metabolite trimethylamine-N-oxide (TMAO) induced apoptosis in renal tubular epithelial cells, which was independently associated with the urinary albumin/creatinine ratio (UACR) in DKD patients (OR = 1.52, 95%CI 1.18–1.96).¹³³ The aforementioned mechanisms provide the foundation for dietary modification strategies. The first strategy involves the implementation of a high-fiber/resistant starch diet ($\geq 30 \text{ g per}$



day) to enhance uremic toxin clearance through the enrichment of SCFAs-producing bacteria. The second strategy focuses on the incorporation of Mediterranean dietary polyphenols (e.g., olive oil hydroxytyrosol) to selectively promote *Akkermansia muciniphila* and other beneficial bacteria and inhibit the overgrowth of pathogenic Proteobacteria. In addition, prebiotic/prebiotic combination interventions (e.g., oligofructose + *bifidobacteria*) restored GM diversity and lowered TMAO levels. Future studies must further elucidate the profile of flora characteristics and personalized dietary targets at different DKD stages to optimize the precise GM-based nutritional treatment strategy.

7.2.4 Develop comprehensive guidelines. Researchers, clinicians, and policymakers must collaborate to develop comprehensive dietary guidelines for DKD. These guidelines must be evidence-based, culturally sensitive, and adaptable to patients' individual needs.

7.2.5 Patient education and support. Enhanced patient education and support are essential for improving adherence to dietary interventions. This may involve creating digital tools and resources, such as mobile apps or online platforms, to provide personalized dietary advice, track progress, and offer motivational support.

7.2.6 Integration with digital health technologies. Integrating diet management with digital health technologies, such as wearables and mobile health apps, can provide real-time feedback and support to patients, enhancing adherence and treatment outcomes. These technologies can also enable remote monitoring and counseling, improving the accessibility of diet management.

7.2.7 Interdisciplinary research. Encouraging interdisciplinary research and drawing insights from nutritional sciences, nephrology, genomics, and behavioral sciences can facilitate a more comprehensive approach to managing DKD. Collaborative research programs can foster innovation and accelerate the translation of research findings into clinical practice.

8 Conclusion

In summary, dietary therapies show great promise in treating DKD. However, their use must be individualized and closely monitored to maximize benefits and minimize risks. Future research should focus on large-scale, long-term clinical trials to further elucidate the efficacy and safety of these dietary approaches in different DKD patient populations. Combining dietary therapies with pharmacological treatments could pave the way for a comprehensive and effective DKD management strategy, ultimately improving patients' prognosis and quality of life.

Abbreviations

ACEI	Angiotensin-converting enzyme inhibitor
ARB	Angiotensin II receptor blocker

BMI	Body mass index
CKD	Chronic kidney disease
CRP	C-reactive protein
DASH	Dietary approaches to stop hypertension
DKD	Diabetic kidney disease
DPP-4	Dipeptidyl peptidase 4
eGFR	Estimated glomerular filtration rate
ESRD	End-stage renal disease
GLP-1	Glucagon-like peptide 1
HbA1c	Hemoglobin A1c
HDAC	Histone deacetylase
IL-6	Interleukin 6
LPS	Lipopolysaccharide
KD	Ketogenic diet
MED	Mediterranean diet
MODY	Maturity onset diabetes of the young
NAFLD	Non-alcoholic fatty liver disease
NCD	Non-communicable disease
RCT	Randomized controlled trial
RAAS	Renin-angiotensin-aldosterone system
SCFA	Short-chain fatty acid
SGLT2	Sodium-glucose co-transporter 2
SMBG	Self-monitoring of blood glucose
T2DM	Type 2 diabetes mellitus
TNF- α	Tumor necrosis factor alpha
TMAO	Trimethylamine-N-oxide
UACR	Urinary albumin/creatinine ratio

Author contributions

Hongtu Hu and Wei Liang were involved in the conception and design. Hongtu Hu and Wei Liang drafted of the manuscript. Wei Liang and Guohua Ding revised the manuscript critically for intellectual content. Hongtu Hu, Wei Liang and Guohua Ding approved the final version to be published. All authors agree to be accountable for all aspects of work ensuring integrity and accuracy.

Data availability

No datasets were generated or analyzed during the current study.

Conflicts of interest

The authors declare no competing interests.

Acknowledgements

This study was supported by the National Natural Science Foundation of China (82070713 to G. Ding, 81970631 to W. Liang). Fig. 1 and 2 were created with BioRender.com. We extend our apologies to the authors whose contributions



precede this work, as we regretfully acknowledge our inability to cite them in this review article due to the word limit stipulated by the journal's requirements.

References

- 1 C. P. Benziger, G. A. Roth and A. E. Moran, The Global Burden of Disease Study and the Preventable Burden of NCD, *Glob. Heart*, 2016, **11**, 393–397.
- 2 A. H. Mokdad, L. Dwyer-Lindgren, C. Fitzmaurice, R. W. Stubbs, A. Bertozzi-Villa, C. Morozoff, R. Charara, C. Allen, M. Naghavi and C. J. Murray, Trends and Patterns of Disparities in Cancer Mortality Among US Counties, 1980–2014, *J. Am. Med. Assoc.*, 2017, **317**, 388–406.
- 3 N. G. Forouhi, Embracing complexity: making sense of diet, nutrition, obesity and type 2 diabetes, *Diabetologia*, 2023, **66**, 786–799.
- 4 M. C. Thomas, M. Brownlee, K. Susztak, K. Sharma, K. A. Jandeleit-Dahm, S. Zoungas, P. Rossing, P. H. Groop and M. E. Cooper, Diabetic kidney disease, *Nat. Rev. Dis. Primers*, 2015, **1**, 15018.
- 5 D. Tomic, J. E. Shaw and D. J. Magliano, The burden and risks of emerging complications of diabetes mellitus, *Nat. Rev. Endocrinol.*, 2022, **18**, 525–539.
- 6 A. L. Gloyn and D. J. Drucker, Precision medicine in the management of type 2 diabetes, *Lancet Diabetes Endocrinol.*, 2018, **6**, 891–900.
- 7 S. Rovira-Llopis, C. Banuls, N. Diaz-Morales, A. Hernandez-Mijares, M. Rocha and V. M. Victor, Mitochondrial dynamics in type 2 diabetes: Pathophysiological implications, *Redox Biol.*, 2017, **11**, 637–645.
- 8 R. Hariharan, E. N. Odjidja, D. Scott, N. Shivappa, J. R. Hebert, A. Hodge and B. de Courten, The dietary inflammatory index, obesity, type 2 diabetes, and cardiovascular risk factors and diseases, *Obes. Rev.*, 2022, **23**, e13349.
- 9 M. Bluher, M. Aras, L. J. Aronne, R. L. Batterham, F. Giorgino, L. Ji, K. H. Pietilainen, O. Schnell, E. Tonchevska and J. P. H. Wilding, New insights into the treatment of obesity, *Diabetes, Obes. Metab.*, 2023, **25**, 2058–2072.
- 10 M. E. Piche, A. Tchernof and J. P. Despres, Obesity Phenotypes, Diabetes, and Cardiovascular Diseases, *Circ. Res.*, 2020, **126**, 1477–1500.
- 11 W. M. de Vos, H. Tilg, M. Van Hul and P. D. Cani, Gut microbiome and health: mechanistic insights, *Gut*, 2022, **71**, 1020–1032.
- 12 A. Ceriello and F. Prattichizzo, Variability of risk factors and diabetes complications, *Cardiovasc. Diabetol.*, 2021, **20**, 101.
- 13 A. Odermatt, The Western-style diet: a major risk factor for impaired kidney function and chronic kidney disease, *Am. J. Physiol.: Cell Physiol.*, 2011, **301**, F919–F931.
- 14 A. Mirzababaei, F. Abaj, Z. Roumi, R. A. Khosroshahi, Y. Aali, C. C. T. Clark, M. Radmehr and K. Mirzaei, Consumption of red, white, and processed meat and odds of developing kidney damage and diabetic nephropathy (DN) in women: a case control study, *Sci. Rep.*, 2024, **14**, 10344.
- 15 R. N. Moorthi, C. J. Vorland and K. M. Hill Gallant, Diet and Diabetic Kidney Disease: Plant Versus Animal Protein, *Curr. Diabetes Rep.*, 2017, **17**, 15.
- 16 M. M. Adeva-Andany, C. Fernandez-Fernandez, N. Carneiro-Freire, M. Vila-Altesor and E. Ameneiros-Rodriguez, The differential effect of animal versus vegetable dietary protein on the clinical manifestations of diabetic kidney disease in humans, *Clin. Nutr. ESPEN*, 2022, **48**, 21–35.
- 17 W. L. Lau, T. Tran, C. M. Rhee, K. Kalantar-Zadeh and N. D. Vaziri, Diabetes and the Gut Microbiome, *Semin. Nephrol.*, 2021, **41**, 104–113.
- 18 Y. Lytvyn, P. Bjornstad, D. H. van Raalte, H. L. Heerspink and D. Z. I. Cherney, The New Biology of Diabetic Kidney Disease-Mechanisms and Therapeutic Implications, *Endocr. Rev.*, 2020, **41**, 202–231.
- 19 K. R. Tuttle, R. Agarwal, C. E. Alpers, G. L. Bakris, F. C. Brosius, P. Kolkhof and J. Uribarri, Molecular mechanisms and therapeutic targets for diabetic kidney disease, *Kidney Int.*, 2022, **102**, 248–260.
- 20 S. Jiang, J. Fang and W. Li, Protein restriction for diabetic kidney disease, *Cochrane Database Syst. Rev.*, 2023, **1**, CD014906.
- 21 S. Castro-Barquero, A. M. Ruiz-Leon, M. Sierra-Perez, R. Estruch and R. Casas, Dietary Strategies for Metabolic Syndrome: A Comprehensive Review, *Nutrients*, 2020, **12**, 2983.
- 22 C. Davis, J. Bryan, J. Hodgson and K. Murphy, Definition of the Mediterranean Diet; a Literature Review, *Nutrients*, 2015, **7**, 9139–9153.
- 23 L. J. Dominguez, G. Di Bella, N. Veronese and M. Barbagallo, Impact of Mediterranean Diet on Chronic Non-Communicable Diseases and Longevity, *Nutrients*, 2021, **13**, 2028.
- 24 E. A. Hu, L. M. Steffen, M. E. Grams, D. C. Crews, J. Coresh, L. J. Appel and C. M. Rebholz, Dietary patterns and risk of incident chronic kidney disease: the Atherosclerosis Risk in Communities study, *Am. J. Clin. Nutr.*, 2019, **110**, 713–721.
- 25 Z. Ungvari, M. Fekete, J. T. Fekete, G. Grosso, A. Ungvari and B. Györfy, Adherence to the Mediterranean diet and its protective effects against colorectal cancer: a meta-analysis of 26 studies with 2,217,404 participants, *Geroscience*, 2025, **47**, 1105–1121.
- 26 Y. Xiong, X. Shi, X. Xiong, S. Li, H. Zhao, H. Song, J. Wang, L. Zhang, S. You, G. Ji, B. Liu and N. Wu, A systematic review and meta-analysis of randomized controlled trials: effects of mediterranean diet and low-fat diet on liver enzymes and liver fat content of NAFLD, *Food Funct.*, 2024, **15**, 8248–8257.



- 27 B. A. Seelarbokus, E. Menozzi, A. H. V. Schapira, A. Z. Kalea and J. Macnaughtan, Mediterranean Diet Adherence, Gut Microbiota and Parkinson's Disease: A Systematic Review, *Nutrients*, 2024, **16**, 2181.
- 28 F. Jannasch, J. Kroger and M. B. Schulze, Dietary Patterns and Type 2 Diabetes: A Systematic Literature Review and Meta-Analysis of Prospective Studies, *J. Nutr.*, 2017, **147**, 1174–1182.
- 29 J. G. Sobiecki, F. Imamura, C. R. Davis, S. J. Sharp, A. Koulman, J. M. Hodgson, M. Guevara, M. B. Schulze, J. S. Zheng, C. Agnoli, C. Bonet, S. M. Colorado-Yohar, G. Fagherazzi, P. W. Franks, T. E. Gundersen, F. Jannasch, R. Kaaks, V. Katzke, E. Molina-Montes, P. M. Nilsson, D. Palli, S. Panico, K. Papier, O. Rolandsson, C. Sacerdote, A. Tjonneland, T. Y. N. Tong, Y. T. van der Schouw, J. Danesh, A. S. Butterworth, E. Riboli, K. J. Murphy, N. J. Wareham and N. G. Forouhi, A nutritional biomarker score of the Mediterranean diet and incident type 2 diabetes: Integrated analysis of data from the MedLey randomised controlled trial and the EPIC-InterAct case-cohort study, *PLoS Med.*, 2023, **20**, e1004221.
- 30 C. D. Gardner, M. J. Landry, D. Perelman, C. Petlura, L. R. Durand, L. Aronica, A. Crimarco, K. M. Cunanan, A. Chang, C. C. Dant, J. L. Robinson and S. H. Kim, Effect of a ketogenic diet versus Mediterranean diet on glycated hemoglobin in individuals with prediabetes and type 2 diabetes mellitus: The interventional Keto-Med randomized crossover trial, *Am. J. Clin. Nutr.*, 2022, **116**, 640–652.
- 31 H. A. Al-Aubaidy, A. Dayan, M. A. Deseo, C. Itsiopoulos, D. Jamil, N. R. Hadi and C. J. Thomas, Twelve-Week Mediterranean Diet Intervention Increases Citrus Bioflavonoid Levels and Reduces Inflammation in People with Type 2 Diabetes Mellitus, *Nutrients*, 2021, **13**, 1133.
- 32 M. Vitale, M. Masulli, I. Calabrese, A. A. Rivelles, E. Bonora, S. Signorini, G. Perriello, S. Squatrito, R. Buzzetti, G. Sartore, A. C. Babini, G. Gregori, C. Giordano, G. Clemente, S. Grioni, P. Dolce, G. Riccardi, O. Vaccaro and T. I. S. Group, Impact of a Mediterranean Dietary Pattern and Its Components on Cardiovascular Risk Factors, Glucose Control, and Body Weight in People with Type 2 Diabetes: A Real-Life Study, *Nutrients*, 2018, **10**, 1067.
- 33 T. Seres-Noriega, C. Vinals, V. Perea, A. Mesa, L. Boswell, K. Mariaca, J. Blanco, I. Vinagre, A. Pane, C. Milad, C. Sola, E. Esmatjes, I. Conget, M. Gimenez and A. J. Amor, Adherence to an energy-restricted Mediterranean diet is associated with the presence and burden of carotid atherosclerosis in people with type 1 diabetes, *Diabetes Metab. Res. Rev.*, 2024, **40**, e3783.
- 34 S. Montemayor, C. M. Mascaro, L. Ugarriza, M. Casares, I. Llompard, I. Abete, M. A. Zulet, J. A. Martinez, J. A. Tur and C. Bouzas, Adherence to Mediterranean Diet and NAFLD in Patients with Metabolic Syndrome: The FLIPAN Study, *Nutrients*, 2022, **14**, 3186.
- 35 N. Becerra-Tomas, S. Blanco Mejia, E. Viguiliouk, T. Khan, C. W. C. Kendall, H. Kahleova, D. Rahelic, J. L. Sievenpiper and J. Salas-Salvado, Mediterranean diet, cardiovascular disease and mortality in diabetes: A systematic review and meta-analysis of prospective cohort studies and randomized clinical trials, *Crit. Rev. Food Sci. Nutr.*, 2020, **60**, 1207–1227.
- 36 R. Martin-O'Connor, A. Ramos-Levi, V. Melero, M. Arnoriaga-Rodriguez, A. Barabash, J. Valerio, L. Del Valle, P. de Miguel, A. Diaz, C. Familiar, I. Moraga, A. Duran, M. Cuesta, M. J. Torrejon, M. Martinez-Novillo, C. Marcuello, M. Pazos, M. A. Rubio, P. Matia Marin and A. L. Calle-Pascual, Early Mediterranean-Based Nutritional Intervention Reduces the Rate of Gestational Diabetes in Overweight and Obese Pregnant Women: A Post-Hoc Analysis of the San Carlos Gestational Prevention Study, *Nutrients*, 2024, **16**, 2206.
- 37 C. Qu, J. Zhao, J. Lai, X. Wu, P. Huang, T. Zhu, Y. Li, T. Liu, J. Yuan, N. Wang, M. P. Peppelenbosch, H. Chen, B. Xia and J. Qin, Adherence to a Mediterranean diet is associated with a lower risk of diabetic kidney disease among individuals with hyperglycemia: a prospective cohort study, *BMC Med.*, 2024, **22**, 224.
- 38 A. Jayedi, K. Mirzaei, A. Rashidy-Pour, M. S. Yekaninejad, M. S. Zargar and M. R. Akbari Eidgahi, Dietary approaches to stop hypertension, mediterranean dietary pattern, and diabetic nephropathy in women with type 2 diabetes: A case-control study, *Clin. Nutr. ESPEN*, 2019, **33**, 164–170.
- 39 A. Diaz-Lopez, N. Babio, M. A. Martinez-Gonzalez, D. Corella, A. J. Amor, M. Fito, R. Estruch, F. Aros, E. Gomez-Gracia, M. Fiol, J. Lapetra, L. Serra-Majem, J. Basora, F. J. Basterra-Gortari, V. Zanon-Moreno, M. A. Munoz, J. Salas-Salvado and P. S. Investigators, Mediterranean Diet, Retinopathy, Nephropathy, and Microvascular Diabetes Complications: A Post Hoc Analysis of a Randomized Trial, *Diabetes Care*, 2015, **38**, 2134–2141.
- 40 M. Moradi, E. Daneshzad, M. M. Najafabadi, N. Bellissimo, K. Suitor and L. Azadbakht, Association between adherence to the Mediterranean diet and renal function biomarkers and cardiovascular risk factors among diabetic patients with nephropathy, *Clin. Nutr. ESPEN*, 2020, **40**, 156–163.
- 41 A. De Mauri, D. Carrera, M. Vidali, M. Bagnati, R. Rolla, S. Riso, D. Chiarinotti and M. Torreggiani, Does Mediterranean Adequacy Index Correlate with Cardiovascular Events in Patients with Advanced Chronic Kidney Disease? An Exploratory Study, *Nutrients*, 2022, **14**, 1687.
- 42 R. Zamora-Ros, M. Serafini, R. Estruch, R. M. Lamuela-Raventos, M. A. Martinez-Gonzalez, J. Salas-Salvado, M. Fiol, J. Lapetra, F. Aros, M. I. Covas, C. Andres-Lacueva and P. S. Investigators, Mediterranean diet and non enzymatic antioxidant capacity in the PREDIMED study: evidence for a mechanism of antioxidant tuning, *Nutr., Metab. Cardiovasc. Dis.*, 2013, **23**, 1167–1174.
- 43 V. Tosti, B. Bertozzi and L. Fontana, Health Benefits of the Mediterranean Diet: Metabolic and Molecular Mechanisms, *J. Gerontol., Ser. A*, 2018, **73**, 318–326.



- 44 M. I. Maiorino, G. Bellastella, M. Petrizzo, L. Scappaticcio, D. Giugliano and K. Esposito, Mediterranean diet cools down the inflammatory milieu in type 2 diabetes: the MEDITA randomized controlled trial, *Endocrine*, 2016, **54**, 634–641.
- 45 A. Ceriello, K. Esposito, L. La Sala, G. Pujadas, V. De Nigris, R. Testa, L. Bucciarelli, M. Rondinelli and S. Genovese, The protective effect of the Mediterranean diet on endothelial resistance to GLP-1 in type 2 diabetes: a preliminary report, *Cardiovasc. Diabetol.*, 2014, **13**, 140.
- 46 S. C. Naaman and G. L. Bakris, Diabetic Nephropathy: Update on Pillars of Therapy Slowing Progression, *Diabetes Care*, 2023, **46**, 1574–1586.
- 47 H. Oeseburg, R. A. de Boer, H. Buikema, P. van der Harst, W. H. van Gilst and H. H. Sillje, Glucagon-like peptide 1 prevents reactive oxygen species-induced endothelial cell senescence through the activation of protein kinase A, *Arterioscler., Thromb., Vasc. Biol.*, 2010, **30**, 1407–1414.
- 48 A. Ceriello, K. Esposito, R. Testa, A. R. Bonfigli, M. Marra and D. Giugliano, The possible protective role of glucagon-like peptide 1 on endothelium during the meal and evidence for an “endothelial resistance” to glucagon-like peptide 1 in diabetes, *Diabetes Care*, 2011, **34**, 697–702.
- 49 L. Zhao, F. Zhang, X. Ding, G. Wu, Y. Y. Lam, X. Wang, H. Fu, X. Xue, C. Lu, J. Ma, L. Yu, C. Xu, Z. Ren, Y. Xu, S. Xu, H. Shen, X. Zhu, Y. Shi, Q. Shen, W. Dong, R. Liu, Y. Ling, Y. Zeng, X. Wang, Q. Zhang, J. Wang, L. Wang, Y. Wu, B. Zeng, H. Wei, M. Zhang, Y. Peng and C. Zhang, Gut bacteria selectively promoted by dietary fibers alleviate type 2 diabetes, *Science*, 2018, **359**, 1151–1156.
- 50 D. K. Mandaliya and S. Seshadri, Short Chain Fatty Acids, pancreatic dysfunction and type 2 diabetes, *Pancreatol.*, 2019, **19**, 280–284.
- 51 A. Puddu, R. Sanguineti, F. Montecucco and G. L. Viviani, Evidence for the gut microbiota short-chain fatty acids as key pathophysiological molecules improving diabetes, *Mediators Inflammation*, 2014, **2014**, 162021.
- 52 P. Mirtschink, C. Jang, Z. Arany and W. Krek, Fructose metabolism, cardiometabolic risk, and the epidemic of coronary artery disease, *Eur. Heart J.*, 2018, **39**, 2497–2505.
- 53 F. Chicco, S. Magri, A. Cingolani, D. Paduano, M. Pesenti, F. Zara, F. Tumbarello, E. Urru, A. Melis, L. Casula, M. C. Fantini and P. Usai, Multidimensional Impact of Mediterranean Diet on IBD Patients, *Inflammatory Bowel Dis.*, 2021, **27**, 1–9.
- 54 D. Dynka, K. Kowalcze and A. Paziewska, The Role of Ketogenic Diet in the Treatment of Neurological Diseases, *Nutrients*, 2022, **14**, 5003.
- 55 D. Barry, S. Ellul, L. Watters, D. Lee, R. Haluska Jr. and R. White, The ketogenic diet in disease and development, *Int. J. Dev. Neurosci.*, 2018, **68**, 53–58.
- 56 L. Crosby, B. Davis, S. Joshi, M. Jardine, J. Paul, M. Neola and N. D. Barnard, Ketogenic Diets and Chronic Disease: Weighing the Benefits Against the Risks, *Front. Nutr.*, 2021, **8**, 702802.
- 57 M. N. Roberts, M. A. Wallace, A. A. Tomilov, Z. Zhou, G. R. Marcotte, D. Tran, G. Perez, E. Gutierrez-Casado, S. Koike, T. A. Knotts, D. M. Imai, S. M. Griffey, K. Kim, K. Hagopian, M. Z. McMackin, F. G. Haj, K. Baar, G. A. Cortopassi, J. J. Ramsey and J. A. Lopez-Dominguez, A Ketogenic Diet Extends Longevity and Healthspan in Adult Mice, *Cell Metab.*, 2017, **26**, 539–546.
- 58 J. C. Newman, A. J. Covarrubias, M. Zhao, X. Yu, P. Gut, C. P. Ng, Y. Huang, S. Haldar and E. Verdin, Ketogenic Diet Reduces Midlife Mortality and Improves Memory in Aging Mice, *Cell Metab.*, 2017, **26**, 547–557.
- 59 M. Ferrer, N. Mourikis, E. E. Davidson, S. O. Kleeman, M. Zaccaria, J. Habel, R. Rubino, Q. Gao, T. R. Flint, L. Young, C. M. Connell, M. J. Lukey, M. D. Goncalves, E. P. White, A. R. Venkitaraman and T. Janowitz, Ketogenic diet promotes tumor ferroptosis but induces relative corticosterone deficiency that accelerates cachexia, *Cell Metab.*, 2023, **35**, 1147–1162.
- 60 P. Puchalska and P. A. Crawford, Multi-dimensional Roles of Ketone Bodies in Fuel Metabolism, Signaling, and Therapeutics, *Cell Metab.*, 2017, **25**, 262–284.
- 61 J. A. Torres, S. L. Kruger, C. Broderick, T. Amaralkhagva, S. Agrawal, J. R. Dodam, M. Mrug, L. A. Lyons and T. Weimbs, Ketosis Ameliorates Renal Cyst Growth in Polycystic Kidney Disease, *Cell Metab.*, 2019, **30**, 1007–1023.
- 62 S. Kumar, T. Behl, M. Sachdeva, A. Sehgal, S. Kumari, A. Kumar, G. Kaur, H. N. Yadav and S. Bungau, Implicating the effect of ketogenic diet as a preventive measure to obesity and diabetes mellitus, *Life Sci.*, 2021, **264**, 118661.
- 63 C. Zhou, M. Wang, J. Liang, G. He and N. Chen, Ketogenic Diet Benefits to Weight Loss, Glycemic Control, and Lipid Profiles in Overweight Patients with Type 2 Diabetes Mellitus: A Meta-Analysis of Randomized Controlled Trials, *Int. J. Environ. Res. Public Health*, 2022, **19**, 10429.
- 64 S. Li, G. Lin, J. Chen, Z. Chen, F. Xu, F. Zhu, J. Zhang and S. Yuan, The effect of periodic ketogenic diet on newly diagnosed overweight or obese patients with type 2 diabetes, *BMC Endocr. Disord.*, 2022, **22**, 34.
- 65 A. Basolo, S. Magno, F. Santini and G. Ceccarini, Ketogenic Diet and Weight Loss: Is There an Effect on Energy Expenditure?, *Nutrients*, 2022, **14**, 1814.
- 66 F. Brouns, Overweight and diabetes prevention: is a low-carbohydrate-high-fat diet recommendable?, *Eur. J. Nutr.*, 2018, **57**, 1301–1312.
- 67 American Diabetes Association, Standards of medical care in diabetes–2013, *Diabetes Care*, 2013, **36**(Suppl 1), S11–S66.
- 68 A. Paoli, L. Mancin, A. Bianco, E. Thomas, J. F. Mota and F. Piccini, Ketogenic Diet and Microbiota: Friends or Enemies?, *Genes*, 2019, **10**, 534.
- 69 A. Koliada, G. Syzenko, V. Moseiko, L. Budovska, K. Puchkov, V. Perederiy, Y. Gavalko, A. Dorofeyev, M. Romanenko, S. Tkach, L. Sineok, O. Lushchak and A. Vaiserman, Association between body mass index and



- Firmicutes/Bacteroidetes ratio in an adult Ukrainian population, *BMC Microbiol.*, 2017, **17**, 120.
- 70 C. E. Forsythe, S. D. Phinney, M. L. Fernandez, E. E. Quann, R. J. Wood, D. M. Bibus, W. J. Kraemer, R. D. Feinman and J. S. Volek, Comparison of low fat and low carbohydrate diets on circulating fatty acid composition and markers of inflammation, *Lipids*, 2008, **43**, 65–77.
 - 71 I. Tomita, S. Kume, S. Sugahara, N. Osawa, K. Yamahara, M. Yasuda-Yamahara, N. Takeda, M. Chin-Kanasaki, T. Kaneko, E. Mayoux, M. Mark, M. Yanagita, H. Ogita, S. I. Araki and H. Maegawa, SGLT2 Inhibition Mediates Protection from Diabetic Kidney Disease by Promoting Ketone Body-Induced mTORC1 Inhibition, *Cell Metab.*, 2020, **32**, 404–419.
 - 72 T. Greco, T. C. Glenn, D. A. Hovda and M. L. Prins, Ketogenic diet decreases oxidative stress and improves mitochondrial respiratory complex activity, *J. Cereb. Blood Flow Metab.*, 2016, **36**, 1603–1613.
 - 73 V. J. Miller, R. A. LaFountain, E. Barnhart, T. S. Sapper, J. Short, W. D. Arnold, P. N. Hyde, C. D. Crabtree, M. L. Kackley, W. J. Kraemer, F. A. Villamena and J. S. Volek, A ketogenic diet combined with exercise alters mitochondrial function in human skeletal muscle while improving metabolic health, *Am. J. Physiol. Endocrinol. Metab.*, 2020, **319**, E995–E1007.
 - 74 W. S. Yancy, Jr., M. Foy, A. M. Chalecki, M. C. Vernon and E. C. Westman, A low-carbohydrate, ketogenic diet to treat type 2 diabetes, *Nutr. Metab.*, 2005, **2**, 34.
 - 75 Z. Guo, F. Zhong, M. Hou, J. Xie, A. Z. Zhang, X. Li, Y. Li, B. Chang and J. Yang, Key enzyme in charge of ketone reabsorption of renal tubular SMCT1 may be a new target in diabetic kidney disease, *Nephrol., Dial., Transplant.*, 2023, **38**, 2754–2766.
 - 76 M. M. Poplawski, J. W. Mastaitis, F. Isoda, F. Grosjean, F. Zheng and C. V. Mobbs, Reversal of diabetic nephropathy by a ketogenic diet, *PLoS One*, 2011, **6**, e18604.
 - 77 S. R. Wan, F. Y. Teng, W. Fan, B. T. Xu, X. Y. Li, X. Z. Tan, M. Guo, C. L. Gao, C. X. Zhang, Z. Z. Jiang and Y. Xu, BDH1-mediated betaOHB metabolism ameliorates diabetic kidney disease by activation of NRF2-mediated anti-oxidative pathway, *Aging*, 2023, **15**, 13384–13410.
 - 78 A. N. Friedman, M. Chambers, L. M. Kamendulis and J. Temmerman, Short-term changes after a weight reduction intervention in advanced diabetic nephropathy, *Clin. J. Am. Soc. Nephrol.*, 2013, **8**, 1892–1898.
 - 79 G. J. Ko, C. M. Rhee, K. Kalantar-Zadeh and S. Joshi, The Effects of High-Protein Diets on Kidney Health and Longevity, *J. Am. Soc. Nephrol.*, 2020, **31**, 1667–1679.
 - 80 X. Tong, Y. Deng, L. Liu, X. Tang, T. Yu, J. Gan, Q. Cai, R. Luo and N. Xiao, Clinical implementation of ketogenic diet in children with drug-resistant epilepsy: Advantages, disadvantages, and difficulties, *Seizure*, 2022, **99**, 75–81.
 - 81 B. G. Allen, S. K. Bhatia, C. M. Anderson, J. M. Eichenberger-Gilmore, Z. A. Sibenaller, K. A. Mapuskar, J. D. Schoenfeld, J. M. Buatti, D. R. Spitz and M. A. Fath, Ketogenic diets as an adjuvant cancer therapy: History and potential mechanism, *Redox Biol.*, 2014, **2**, 963–970.
 - 82 D. Tinguely, J. Gross and C. Kosinski, Efficacy of Ketogenic Diets on Type 2 Diabetes: a Systematic Review, *Curr. Diabetes Rep.*, 2021, **21**, 32.
 - 83 D. Tang, Q. Tang, W. Huang, Y. Zhang, Y. Tian and X. Fu, Fasting: From Physiology to Pathology, *Adv. Sci.*, 2023, **10**, e2204487.
 - 84 K. A. Varady, S. Cienfuegos, M. Ezpeleta and K. Gabel, Clinical application of intermittent fasting for weight loss: progress and future directions, *Nat. Rev. Endocrinol.*, 2022, **18**, 309–321.
 - 85 H. Kord-Varkaneh, A. Salehi-Sahlabadi, G. M. Tinsley, H. O. Santos and A. Hekmatdoost, Effects of time-restricted feeding (16/8) combined with a low-sugar diet on the management of non-alcoholic fatty liver disease: A randomized controlled trial, *Nutrition*, 2023, **105**, 111847.
 - 86 S. Gallage, A. Ali, J. E. Barragan Avila, N. Seymen, P. Ramadori, V. Joerke, L. Zizmare, D. Aicher, I. K. Gopalsamy, W. Fong, J. Kosla, E. Focaccia, X. Li, S. Yousuf, T. Sijmonsma, M. Rahbari, K. S. Kommos, A. Billeter, S. Prokosch, U. Rothermel, F. Mueller, J. Hetzer, D. Heide, B. Schinkel, T. Machauer, B. Pichler, N. P. Malek, T. Longerich, S. Roth, A. J. Rose, J. Schwenck, C. Trautwein, M. M. Karimi and M. Heikenwalder, A 5 : 2 intermittent fasting regimen ameliorates NASH and fibrosis and blunts HCC development via hepatic PPARalpha and PCK1, *Cell Metab.*, 2024, **36**, 1371–1393.
 - 87 J. Kang, X. Shi, J. Fu, H. Li, E. Ma and W. Chen, Effects of an Intermittent Fasting 5 : 2 Plus Program on Body Weight in Chinese Adults with Overweight or Obesity: A Pilot Study, *Nutrients*, 2022, **14**, 4734.
 - 88 E. Duregon, M. E. Fernandez, J. Martinez Romero, C. Di Germanio, M. Cabassa, R. Voloshchuk, M. R. Ehrlich-Mora, J. M. Moats, S. Wong, O. Bosomptra, A. Rudderow, C. H. Morrell, S. Camandola, N. L. Price, M. A. Aon, M. Bernier and R. de Cabo, Prolonged fasting times reap greater geroprotective effects when combined with caloric restriction in adult female mice, *Cell Metab.*, 2023, **35**, 1179–1194.
 - 89 O. Strilbytska, S. Klishch, K. B. Storey, A. Koliada and O. Lushchak, Intermittent fasting and longevity: From animal models to implication for humans, *Ageing Res. Rev.*, 2024, **96**, 102274.
 - 90 S. Y. Chair, H. Cai, X. Cao, Y. Qin, H. Y. Cheng and M. T. Ng, Intermittent Fasting in Weight Loss and Cardiometabolic Risk Reduction: A Randomized Controlled Trial, *J. Nurs. Res.*, 2022, **30**, e185.
 - 91 A. Parvaresh, R. Razavi, B. Abbasi, K. Yaghoobloo, A. Hassanzadeh, N. Mohammadifard, S. M. Safavi, A. Hadi and C. C. T. Clark, Modified alternate-day fasting vs. calorie restriction in the treatment of patients with metabolic syndrome: A randomized clinical trial, *Complement. Ther. Med.*, 2019, **47**, 102187.



- 92 S. M. Secor and H. V. Carey, Integrative Physiology of Fasting, *Compr. Physiol.*, 2016, **6**, 773–825.
- 93 S. Drinda, F. Grundler, T. Neumann, T. Lehmann, N. Steckhan, A. Michalsen and F. Wilhelmi de Toledo, Effects of Periodic Fasting on Fatty Liver Index-A Prospective Observational Study, *Nutrients*, 2019, **11**, 2601.
- 94 E. F. Sutton, R. Beyl, K. S. Early, W. T. Cefalu, E. Ravussin and C. M. Peterson, Early Time-Restricted Feeding Improves Insulin Sensitivity, Blood Pressure, and Oxidative Stress Even without Weight Loss in Men with Prediabetes, *Cell Metab.*, 2018, **27**, 1212–1221.
- 95 L. Guo, Y. Xi, W. Jin, H. Yuan, G. Qin, S. Chen, L. Zhang, Y. Liu, X. Cheng, W. Liu and D. Yu, A 5 : 2 Intermittent Fasting Meal Replacement Diet and Glycemic Control for Adults With Diabetes: The EARLY Randomized Clinical Trial, *JAMA Netw. Open*, 2024, **7**, e2416786.
- 96 E. Beli, Y. Yan, L. Moldovan, C. P. Vieira, R. Gao, Y. Duan, R. Prasad, A. Bhatwadekar, F. A. White, S. D. Townsend, L. Chan, C. N. Ryan, D. Morton, E. G. Moldovan, F. I. Chu, G. Y. Oudit, H. Derendorf, L. Adorini, X. X. Wang, C. Evans-Molina, R. G. Mirmira, M. E. Boulton, M. C. Yoder, Q. Li, M. Levi, J. V. Busik and M. B. Grant, Restructuring of the Gut Microbiome by Intermittent Fasting Prevents Retinopathy and Prolongs Survival in db/db Mice, *Diabetes*, 2018, **67**, 1867–1879.
- 97 H. J. Weir, P. Yao, F. K. Huynh, C. C. Escoubas, R. L. Goncalves, K. Burkewitz, R. Laboy, M. D. Hirschey and W. B. Mair, Dietary Restriction and AMPK Increase Lifespan via Mitochondrial Network and Peroxisome Remodeling, *Cell Metab.*, 2017, **26**, 884–896.
- 98 P. Rojas-Morales, J. C. Leon-Contreras, O. E. Aparicio-Trejo, J. G. Reyes-Ocampo, O. N. Medina-Campos, A. S. Jimenez-Osorio, S. Gonzalez-Reyes, B. Marquina-Castillo, R. Hernandez-Pando, D. Barrera-Oviedo, L. G. Sanchez-Lozada, J. Pedraza-Chaverri and E. Tapia, Fasting reduces oxidative stress, mitochondrial dysfunction and fibrosis induced by renal ischemia-reperfusion injury, *Free Radicals Biol. Med.*, 2019, **135**, 60–67.
- 99 H. Jamshed, R. A. Beyl, D. L. Della Manna, E. S. Yang, E. Ravussin and C. M. Peterson, Early Time-Restricted Feeding Improves 24-Hour Glucose Levels and Affects Markers of the Circadian Clock, Aging, and Autophagy in Humans, *Nutrients*, 2019, **11**, 1234.
- 100 F. Wilhelmi de Toledo, F. Grundler, A. Bergouignan, S. Drinda and A. Michalsen, Safety, health improvement and well-being during a 4 to 21-day fasting period in an observational study including 1422 subjects, *PLoS One*, 2019, **14**, e0209353.
- 101 B. E. Wickman, B. Enkhmaa, R. Ridberg, E. Romero, M. Cadeiras, F. Meyers and F. Steinberg, Dietary Management of Heart Failure: DASH Diet and Precision Nutrition Perspectives, *Nutrients*, 2021, **13**, 4424.
- 102 A. A. Sangouni, M. Hosseinzadeh and K. Parastouei, The effect of dietary approaches to stop hypertension (DASH) diet on fatty liver and cardiovascular risk factors in subjects with metabolic syndrome: a randomized controlled trial, *BMC Endocr. Disord.*, 2024, **24**, 126.
- 103 X. Zhou, X. Lin, J. Yu, Y. Yang, H. Muzammel, S. Amissi, V. B. Schini-Kerth, X. Lei, P. A. Jose, J. Yang and D. Shi, Effects of DASH diet with or without time-restricted eating in the management of stage 1 primary hypertension: a randomized controlled trial, *Nutr. J.*, 2024, **23**, 65.
- 104 X. Theodoridis, M. Chourdakis, L. Chrysoula, V. Chroni, I. Tirodimos, K. Dipla, E. Gkaliagkousi and A. Triantafyllou, Adherence to the DASH Diet and Risk of Hypertension: A Systematic Review and Meta-Analysis, *Nutrients*, 2023, **15**, 3261.
- 105 Y. Song, A. J. Lobene, Y. Wang and K. M. Hill Gallant, The DASH Diet and Cardiometabolic Health and Chronic Kidney Disease: A Narrative Review of the Evidence in East Asian Countries, *Nutrients*, 2021, **13**, 984.
- 106 F. Shirani, A. Salehi-Abargouei and L. Azadbakht, Effects of Dietary Approaches to Stop Hypertension (DASH) diet on some risk for developing type 2 diabetes: a systematic review and meta-analysis on controlled clinical trials, *Nutrition*, 2013, **29**, 939–947.
- 107 T. M. Campbell, E. K. Campbell, J. Attia, K. Ventura, T. Mathews, K. H. Chhabra, L. M. Blanchard, N. Wixom, T. S. Faniyan, D. R. Peterson, D. K. Harrington and S. D. Wittlin, The acute effects of a DASH diet and whole food, plant-based diet on insulin requirements and related cardiometabolic markers in individuals with insulin-treated type 2 diabetes, *Diabetes Res. Clin. Pract.*, 2023, **202**, 110814.
- 108 L. Mu, P. Yu, H. Xu, T. Gong, D. Chen, J. Tang, Y. Zou, H. Rao, Y. Mei and L. Mu, Effect of sodium reduction based on the DASH diet on blood pressure in hypertensive patients with type 2 diabetes, *Nutr. Hosp.*, 2022, **39**, 537–546.
- 109 L. R. Saslow, L. M. Jones, A. Sen, J. A. Wolfson, H. L. Diez, A. O'Brien, C. W. Leung, H. Bayandorian, J. Daubenmier, A. L. Missel and C. Richardson, Comparing Very Low-Carbohydrate vs DASH Diets for Overweight or Obese Adults With Hypertension and Prediabetes or Type 2 Diabetes: A Randomized Trial, *Ann. Fam. Med.*, 2023, **21**, 256–263.
- 110 C. M. Carvalho, L. A. Gross, M. J. de Azevedo and L. V. Viana, Dietary Fiber Intake (Supplemental or Dietary Pattern Rich in Fiber) and Diabetic Kidney Disease: A Systematic Review of Clinical Trials, *Nutrients*, 2019, **11**, 347.
- 111 T. Naber and S. Purohit, Chronic Kidney Disease: Role of Diet for a Reduction in the Severity of the Disease, *Nutrients*, 2021, **13**, 3277.
- 112 S. Y. Jeong, C. C. Wee, L. C. Kovell, T. B. Plante, E. R. Miller 3rd, L. J. Appel, K. J. Mukamal and S. P. Juraschek, Effects of Diet on 10-Year Atherosclerotic Cardiovascular Disease Risk (from the DASH Trial), *Am. J. Cardiol.*, 2023, **187**, 10–17.
- 113 A. Mirzababaei, F. Abaj, S. Hajishizari, N. Bahrampour, S. Noori, A. M. Barekzai, D. Hosseininassab, C. C. T. Clark



- and K. Mirzaei, The association of dietary approaches to stop hypertension (DASH) with the odds of diabetic nephropathy and metabolic markers in women: a case-control study, *BMC Women's Health*, 2023, **23**, 63.
- 114 S. M. Hargreaves, D. L. Rosenfeld, A. V. B. Moreira and R. P. Zandonadi, Plant-based and vegetarian diets: an overview and definition of these dietary patterns, *Eur. J. Nutr.*, 2023, **62**, 1109–1121.
 - 115 C. Agnoli, L. Baroni, I. Bertini, S. Ciappellano, A. Fabbri, S. Goggi, D. Metro, M. Papa, R. Sbarbati, M. L. Scarino, N. Pellegrini and S. Sieri, A comprehensive review of healthy effects of vegetarian diets, *Nutr., Metab. Cardiovasc. Dis.*, 2023, **33**, 1308–1315.
 - 116 P. D. Lopez, E. H. Cativo, S. A. Atlas and C. Rosendorff, The Effect of Vegan Diets on Blood Pressure in Adults: A Meta-Analysis of Randomized Controlled Trials, *Am. J. Med.*, 2019, **132**, 875–883.
 - 117 L. Hardt, Y. Mahamat-Saleh, D. Aune and S. Schlesinger, Plant-Based Diets and Cancer Prognosis: a Review of Recent Research, *Curr. Nutr. Rep.*, 2022, **11**, 695–716.
 - 118 F. Liang, J. Fu, G. Turner-McGrievy, Y. Wang, N. Qiu, K. Ding, J. Zeng, J. B. Moore and R. Li, Association of Body Mass Index and Plant-Based Diet with Cognitive Impairment among Older Chinese Adults: A Prospective, Nationwide Cohort Study, *Nutrients*, 2022, **14**, 3132.
 - 119 A. D. Termannsen, C. S. Sondergaard, K. Faerch, T. H. Andersen, A. Raben and J. S. Quist, Effects of Plant-Based Diets on Markers of Insulin Sensitivity: A Systematic Review and Meta-Analysis of Randomised Controlled Trials, *Nutrients*, 2024, **16**, 2110.
 - 120 S. Tonstad, K. Stewart, K. Oda, M. Batech, R. P. Herring and G. E. Fraser, Vegetarian diets and incidence of diabetes in the Adventist Health Study-2, *Nutr., Metab. Cardiovasc. Dis.*, 2013, **23**, 292–299.
 - 121 H. Kahleova, K. F. Petersen, G. I. Shulman, J. Alwarith, E. Rembert, A. Tura, M. Hill, R. Holubkov and N. D. Barnard, Effect of a Low-Fat Vegan Diet on Body Weight, Insulin Sensitivity, Postprandial Metabolism, and Intramyocellular and Hepatocellular Lipid Levels in Overweight Adults: A Randomized Clinical Trial, *JAMA Netw. Open*, 2020, **3**, e2025454.
 - 122 H. Kahleova, M. Matoulek, H. Malinska, O. Oliyarnik, L. Kazdova, T. Neskudla, A. Skoch, M. Hajek, M. Hill, M. Kahle and T. Pelikanova, Vegetarian diet improves insulin resistance and oxidative stress markers more than conventional diet in subjects with Type 2 diabetes, *Diabetic Med.*, 2011, **28**, 549–559.
 - 123 C. A. Mocanu, T. P. Simionescu, A. E. Mocanu and L. Garneata, Plant-Based versus Animal-Based Low Protein Diets in the Management of Chronic Kidney Disease, *Nutrients*, 2021, **13**, 3721.
 - 124 M. M. Jibani, L. L. Bloodworth, E. Foden, K. D. Griffiths and O. P. Galpin, Predominantly vegetarian diet in patients with incipient and early clinical diabetic nephropathy: effects on albumin excretion rate and nutritional status, *Diabetic Med.*, 1991, **8**, 949–953.
 - 125 A. Perez-Torres, A. Caverni-Munoz and E. Gonzalez Garcia, Mediterranean Diet and Chronic Kidney Disease (CKD): A Practical Approach, *Nutrients*, 2022, **15**, 97.
 - 126 S. Kundu, K. S. Hossain, A. Moni, M. S. Zahan, M. M. Rahman and M. J. Uddin, Potentials of ketogenic diet against chronic kidney diseases: pharmacological insights and therapeutic prospects, *Mol. Biol. Rep.*, 2022, **49**, 9749–9758.
 - 127 M. Charkviani, C. Thongprayoon, S. Tangpanithandee, P. Krisanapan, J. Miao, M. A. Mao and W. Cheungpasitporn, Effects of Mediterranean Diet, DASH Diet, and Plant-Based Diet on Outcomes among End Stage Kidney Disease Patients: A Systematic Review and Meta-Analysis, *Clin. Pract.*, 2022, **13**, 41–51.
 - 128 A. K. Bello, J. Kurzawa, M. A. Osman, M. E. Olah, A. Lloyd, N. Wiebe, S. Habib, U. Qarni, S. Shojai and R. P. Pauly, Impact of Ramadan fasting on kidney function and related outcomes in patients with chronic kidney disease: a systematic review protocol, *BMJ Open*, 2019, **9**, e022710.
 - 129 A. Gluba-Brzozka, B. Franczyk and J. Rysz, Vegetarian Diet in Chronic Kidney Disease-A Friend or Foe, *Nutrients*, 2017, **9**, 374.
 - 130 M. Deng, X. Li, W. Li, J. Gong, X. Zhang, S. Ge and L. Zhao, Short-Chain Fatty Acids Alleviate Hepatocyte Apoptosis Induced by Gut-Derived Protein-Bound Uremic Toxins, *Front. Nutr.*, 2021, **8**, 756730.
 - 131 F. Wang, C. Liu, L. Ren, Y. Li, H. Yang, Y. Yu and W. Xu, Sanziguben polysaccharides improve diabetic nephropathy in mice by regulating gut microbiota to inhibit the TLR4/NF-kappaB/NLRP3 signalling pathway, *Pharm. Biol.*, 2023, **61**, 427–436.
 - 132 P. Angoorani, H. S. Ejtahed, S. Hasani-Ranjbar, S. D. Siadat, A. R. Soroush and B. Larijani, Gut microbiota modulation as a possible mediating mechanism for fasting-induced alleviation of metabolic complications: a systematic review, *Nutr. Metab.*, 2021, **18**, 105.
 - 133 J. Lee, J. Lee, K. Kim, J. Lee, Y. Jung, J. S. Hyeon, A. Seo, W. Jin, B. Weon, N. Shin, S. Kim, C. S. Lim, Y. S. Kim, J. P. Lee, G. S. Hwang and S. H. Yang, Antibiotic-induced intestinal microbiota depletion can attenuate the acute kidney injury to chronic kidney disease transition via NADPH oxidase 2 and trimethylamine-N-oxide inhibition, *Kidney Int.*, 2024, **105**, 1239–1253.

