

Albuminuria

Practical bedside approach • Measurement, significance and treatment

01 WHAT IS IT?

Albuminuria means increased urinary albumin excretion and usually indicates damage to the glomerular filtration barrier.

02 HOW DO WE MEASURE IT?

Measure it using the **urine albumin-to-creatinine ratio (ACR)**, preferably in a first-morning sample; a 24-hour collection is usually unnecessary.

CATEGORY	ACR, mg/g	ACR, mg/mmol
A1: normal to mildly increased	<30	<3
A2: moderately increased	30–300	3–30
A3: severely increased	>300	>30

Confirm an elevated result, because exercise, urinary infection, fever and menstruation may temporarily increase it.

03 WHY DOES IT MATTER?

Persistent ACR ≥30 mg/g for at least 3 months is a marker of CKD, even with normal eGFR, and higher albuminuria predicts greater kidney and cardiovascular risk.

04 HOW DO WE TREAT IT?

- Address the underlying cause, control blood pressure and diabetes, and reduce dietary sodium.
- **ACE inhibitors or ARBs** reduce albuminuria in appropriate patients; use one, not both, and monitor creatinine and potassium.
- **SGLT2 inhibitors**, such as dapagliflozin or empagliflozin, provide kidney protection in eligible patients with CKD, including many without diabetes.
- **Finerenone** may be added in selected patients with type 2 diabetes, persistent albuminuria despite an ACE inhibitor or ARB, adequate eGFR and normal potassium.
- Follow **both ACR and eGFR** to assess risk and treatment response.

REFERENCES

KDIGO. Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. Kidney Int. 2024;105(Suppl 4S):S117–S314.

Marta Serwańska-Świątek, MD, PhD • Prepared and approved

Department of Transplantation Medicine, Immunology, Nephrology and Internal Medicine
Medical University of Warsaw • Contact: marta.sweranska-swietek@wum.edu.pl • Updated: October 2026