Case Report

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CLINICAL NUTRITION RESEARCH

Reversing 20 years of diabetes using the carnivore diet in India: a case report

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Diabetes has been well established as one of the deadliest chronic diseases globally. Currently, India is known as the diabetes capital of the world although this disease had been documented in the country for centuries. Current treatment strategies center around oral hypoglycemic drugs, insulin, and the standard 'diabetic diet.' Nonetheless, millions continued to suffer from this chronic disease and its multiple complications. We herein present a case involving a male patient suffering from diabetes for 20 years despite being on medications and a diabetic diet who finally achieved remission of diabetes and hypertension by removing carbohydrates and following a carnivore diet.

Keywords: Type 2 diabetes mellitus; Carbohydrate-restricted diet; Hypertension; Remission induction; Case reports

INTRODUCTION

Diabetes mellitus (DM) is one of the most dangerous chronic noncommunicable diseases, with millions across the globe suffering from its complications. Type 2 DM accounts for almost 95% of all DM cases. Estimates have shown that 588.7 million people (age, 20–79 years) were found to be suffering from DM in 2024. Currently, India ranks second behind China in terms of the number of people with DM, with 89.8 million cases having been documented [1]. Contrary to popular belief, westernization did not cause the emergence of DM in India, considering that this condition had already existed within the country. In fact, two of the first physicians of India, namely Charakha and Sushruta, had described DM in 300 to 400 AD [2]. Osler [3], in his book, described DM as a syndrome caused by a disturbance in carbohydrate metabolism due to various causes, one of which being excess carbohydrate intake. His treatment recommendation was to wean off carbohydrates and place patients on a diet containing 200 g of protein and 135 g of fats, which is akin to a very low carbohydrate ketogenic diet in modern times. In as early as 1797, Rollo [4] revealed that restricting carbohydrates and increasing meat consumption resolved glycosuria in two of his patients.

The American Diabetes Association has focused on glucose lowering drugs while appropriately recommending the reduction of overall carbohydrate consumption. However, they do promote the consumption of fruits, grains, legumes, low fat meat, and dairy, which is counterproductive [5]. Accordingly, low carbohydrate (< 130 g/day) and ketogenic diets (< 50 g/day) have reentered discussions and are being advocated by clinicians and physicians worldwide [6]. A "carnivore diet," which has been touted as the most potent ketogenic diet, eliminates all plant foods and contains high fat, moderate protein, and negligible carbohydrates, which

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emulates diets historically prescribed by Osler [3], Rollo [4], and Newiss [7].

We herein present a case involving a 58-year-old male patient who presented to our department with chronic diabetes for 20 years and a diagnosis of renal cell carcinoma. He was advised to be put on insulin to which he did not consent. We put him on a carnivore diet which led to reversal of his diabetes and hypertension in approximately 4 months.

Ethics statement

Written informed consent was obtained from the family for publication of this case report.

CASE REPORT

A 58-year-old male patient suffering from type 2 DM and hypertension for 20 years visited our department in January 2024 asking for assistance after being advised to start insulin therapy and dialysis. All available records for the last 20 years were reviewed. The patient did not smoke and occasionally consumed alcohol.

His father had suffered from a brain hemorrhage, whereas his mother died due to a sudden cardiac arrest. He had been diagnosed with type 2 DM in May 2004 at 39 years of age with an hemoglobin A1c (HbA1c) of 7%. At this time, he was normotensive with a blood pressure of 110/70 mmHg. His fasting blood sugar (FBS) and postprandial (PP) blood sugar levels were 157 and 150 mg/dL, respectively. His triglyceride (TG)/high-density lipoprotein (HDL) ratio was marginally elevated at 2.90, while his low-density lipoprotein was 137 mg/dL. The patient was initiated on oral metformin (sustained release) before dinner and oral repaglinide (1 mg) three times a day before meals. He was also placed on rosuvastatin (10 mg orally) once daily. The patient, who was an avid golfer, was also advised to continue exercising and consume a diabetic diet. In particular, the patient was advised to consume eight meals a day, which amounted to approximately 260 g of carbohydrates, 74 g of protein, and 63 g of fat.

In June of 2008, a routine checkup reached an HbA1c of 9.0%, FBS of 240 mg/dL, PP blood sugar of 282 mg/dL, and TG/HDL ratio of 4.62. His ultrasound examination also suggested a fatty liver. As such, he was advised to continue the diet and exercise. However, his medications were changed to a combination tablet of metformin (500 mg) and glimepiride (2 mg) twice a day along with oral ramipril (2.5 mg) once daily and a combination capsule of atorvastatin (10 mg) and aspirin (150 mg) once before bedtime.

In August of 2008, he was admitted due to severe back and chest pain and was investigated for a suspected acute coronary syndrome. At discharge, he was diagnosed with uncontrolled DM, dyslipidemia, and severe myalgia. He had an HbA1c of 9.3%, creatine phosphokinase of 445 IU/L (range, 38–174 IU/L), and a TG/HDL ratio of 7.44. He was discharged on oral glimepiride (2 mg) twice daily, metformin (1 g twice daily), and a combination of atorvastatin (10 mg) and aspirin (150 mg) once after dinner. Moreover, he was advised to continue with the conventional diabetic diet.

A routine checkup in January 2011 revealed an FBS of 180 mg/dL, HbA1c of 11.3%, total cholesterol of 218 mg/dL, TG/HDL ratio of 3.64, and low-density lipoprotein of 142 mg/dL. His treadmill test came back negative, and electrocardiography showed normal findings. He was then prescribed a combination drug of metformin (1,000 mg) and glimepiride (2 mg prolonged release) twice daily, saxagliptin (5 mg) once daily, rosuvastatin (10 mg) once before sleeping, and ramipril (2.5 mg) once daily. In March 2011, the patient had a follow-up HbA1c of 8.7% and was advised to continue the same medications along with the diabetic diet.

On the next follow-up in January of 2013 at 47 years of age, he had an HbA1c of 8.9%, microalbuminuria, and fatty liver. He was also diagnosed with early cataract and diabetic retinopathy. The patient was then prescribed glimepiride (4 mg) once before breakfast, metformin (1,000 mg) twice a day, saxagliptin (5 mg) once a day, ramipril (2.5 mg) once daily, and rosuvastatin (10 mg) once daily and was advised to continue with the diabetic diet similar to previous visits.

On his next follow-up in April 2014, he had a PP blood sugar of 293 mg/dL, an HbA1c of 8.7%, and a TG/HDL ratio of 1.4. He was also diagnosed with hypertension, with a blood pressure of 150/90 mmHg. Kidney function and liver function tests were within normal limits. He was advised to continue the diabetic diet and increase walking. The patient was now prescribed glimepiride (4 mg) before breakfast and dinner, a combination of metformin (1 g) and sitagliptin (50 mg) before breakfast and dinner, and pioglitazone (15 mg) before dinner on alternate days. He was also advised to increase ramipril to 5 mg and continue with rosuvastatin (10 mg).

A follow-up with his cardiologist in May 2018 revealed a BP of 146/94 mmHg, pulse rate of 80/min, and normal systemic examination results. He had an FBS of 135 mg/dL, HbA1c of 7.5%, serum creatinine of 0.84 mg/dL, TG/HDL ratio of 1.55, and grade 1 prostatomegaly. He was advised to continue ramipril (5 mg) and rosuvastatin (10 mg), as well as continued with all other oral hypoglycemic agents as previously prescribed.

On June 3, 2021, the patient went to his next follow-up, which revealed a BP of 136/86 mmHg, pulse rate of 74/min, and FBS of 134 mg/dL. During this visit, he was found to have chronic kidney disease with a serum creatinine of 1.33, estimated glomerular filtration rate (eGFR) of 55 mL/min/1.73 m^2, and HbA1c of 12.2%. He was then prescribed ramipril (10 mg) before breakfast, cilnidipine (10 mg) after dinner, metformin (1 g) twice daily with meals, a combination of empagliflozin (25 mg) and linagliptin (5 mg) before breakfast, gliclazide (60 mg) once before breakfast, and rosuvastatin (10 mg) after dinner. He was planned for insulin therapy at a later date and was advised to strictly consume a diabetic diet. A month thereafter, blood tests revealed an HbA1c of 10.7%, serum creatinine of 1.2 mg/dL, and TG/HDL ratio of 5.66. A combination of hydrochlorothiazide (12.5 mg) and ramipril (10 mg) in place of a single ramipril was then added to his prescription. By September 2021, his HbA1c was 6.9%, and he was advised to continue with the previous prescription.

In 2022, the patient underwent cataract surgery on both eyes. In December 2023, blood tests revealed an FBS of 130 mg/dL, PP blood sugar of 180 mg/dL, HbA1c of 8%, hemoglobin of 9.6 g/dL, TG/HDL ratio of 1.88, serum creatinine of 1.9 mg/dL, and eGFR of 39 mL/min/1.73 m^2. His prescription was revised to gliclazide (30 mg) once a day, with the rest remaining the same as that in 2021. He was further diagnosed with chronic kidney disease and was advised visit a nephrologist. His medications were continued as documented in Table 1.

On January 11, 2024, the patient was diagnosed with stage 4 chronic kidney disease with serum creatinine of 2.1 mg/dL, serum urea of 60.3 mg/dL, eGFR of 35.8 mL/min/1.73m^2, and an HbA1c of 7.7%. He was advised to immediately undergo dialysis and was prescribed oral megestrol (160 mg). After his gliclazide dose was increased to 6 mg once a day, he was advised to continue with the combination of empagliflozin (25 mg) and linagliptin (5 mg) and was prescribed long-acting insulin subcutaneously once a day. He was also advised to undergo abdominal ultrasound.

The patient then contacted us on January 12, 2024 as he was reluctant to receive insulin therapy and was not interested in dialysis. Thereafter, we placed him on no carbohydrate carnivore diet comprising nutrient dense foods, with the goal of getting at least 1 g/kg/day of proteins and double the fat. No restrictions were placed on the type of meat consumed. The patient was given the choice of consuming eggs, chicken, mutton, buffalo meat, pork, fatty fish, and prawns. No seed oils were to be used for cooking. Rather, the food had to be cooked in ghee, butter, tallow, or virgin coconut oil. Eggs could be prepared in any way that the patient preferred. Other meats could be minced, in-bone, boneless, ribs, chops, etc. He was advised to track his daily macronutrient intake using a mobile application. No portion control was advised; rather, he was asked to eat ad libitum until satiety. Daily FBS and blood pressure charts were logged onto a shared Excel sheet daily, which was then monitored by us and his sons. Aside from monthly HbA1c assessments, regular follow-up examinations with his primary physician were maintained. The patient also incorporated intermittent fasting and was advised to respond to hunger signals. During this period, he also attempted 24-hour fasts.

From mid-January to April 2024, the patient's average FBS was 100 mg/dL, ranging from 76 to 136 mg/dL. Throughout the whole of April 2024, he had an average FBS of 96 mg/dL, ranging from 76 mg/dL to 110 mg/dL. His average blood pressure from March through April 2024 (blood pressure records from home were not available for previous months) was 125/87 mmHg.

His HbA1c fell from 6.9% from the end of January 2024 to 5.4% by the end of April 2024. His fasting insulin also remained low, ranging from 4.21 to 2.48 mIU/L. His average serum creatinine from February to July 2024 was 1.99 mg/dL, whereas his average serum urea was 76.78 mg/dL. His eGFR by Epidemiology Collaboration (EPI) increased from 28.34 to 40 mL/min/1.73 m^2 (Table 2). In the March of 2024, the patient tapered medications based on self-monitored glucose and blood pressure logs under remote physician supervision. In May 2024, the patient's primary physician (endocrinologist) discontinued all oral hypoglycemic and anti-hypertensive medications, suggesting that the patient had achieved remission from DM and hypertension and did not require further medications for the same.

Unfortunately, ultrasound examination on January 13 suggested an enlarged left kidney with a subtle increase in bilateral renal parenchymal echogenicity along with a large well circumscribed heterogenous, mass lesion involving the lower pole of the posterior cortex of the left kidney with areas of necrosis within the mass. This finding was suggestive of a renal cell carcinoma, which was subsequently confirmed with a positron emission tomography on January 16, with metastasis to the left psoas muscle; right paratracheal, precarinal, pretracheal, right hilar, and left hilar lymph nodes, and both lung fields.

He then underwent palliative immunotherapy in January 2024 with pembrolizumab and radical nephrectomy in June 2024. Thereafter, he underwent radiation therapy for spinal metastasis and was started on a sequence of treatments, including axitinib, everolimus combined with lenvatinib, denosumab (Xgeva), sunitinib (Sutent), and bevacizumab, which continued until March

Table 1. Laboratory values and medications before sought help from our institution

Date	FBS (mg/dL)	PP (mg/dL)	HbA1c (%)	TG/HDL ratio	Medication
May 2004	157	150	7.0	2.90	Metformin Repaglinide Rosuvastatin
June 2008	240	282	9.0	4.62	Metformin Glimepiride Ramipril Aspirin+atorvastatin
August 2008	NA	NA	9.3	7.44	Metformin Glimepiride Aspirin+atorvastatin
January 2011	180	NA	11.3	3.64	Metformin Glimepiride Saxagliptin Rosuvastatin Ramipril
March 2011	NA	NA	8.7	NA	Metformin Glimepiride Saxagliptin Rosuvastatin Ramipril
January 2013	NA	NA	8.9	Check	Metformin Glimepiride Saxagliptin Rosuvastatin Ramipril
April 2014	NA	293	8.7	1.40	Glimepiride Metformin+sitagliptin Pioglitazone Ramipril Rosuvastatin
May 2018	135	NA	7.5	1.55	Glimepiride Metformin+sitagliptin Pioglitazone Ramipril Rosuvastatin
June 2021	134	NA	12.2	NA	Metformin Empagliflozin+linagliptin Gliclazide Cilnidipine Ramipril Rosuvastatin
July 2021	NA	NA	10.7	5.66	Hydrochlorothiazide+ramipril Metformin Empagliflozin+linagliptin Gliclazide Cilnidipine Rosuvastatin
September 2021	NA	NA	6.9	NA	Hydrochlorothiazide+ramipril Metformin Empagliflozin+linagliptin Gliclazide Cilnidipine Rosuvastatin
December 2023	130	180	8.0	1.88	Hydrochlorothiazide+ramipril Metformin Empagliflozin+linagliptin Gliclazide Cilnidipine Rosuvastatin

FBS, fasting blood sugar; PP, postprandial; HbA1c, hemoglobin A1c; TG, triglyceride; HDL, high-density lipoprotein; NA, not available.

Table 2. Blood test results while on the carnivore diet

Date	HbA1c (%)	FBS (mg/dL)	Urea (mg/dL)	Creatinine (mg/dL)	Fasting insulin (mIU/L)	eGFR by EPI (mL/min/1.73 m^2)
January 29, 2024	6.9	100	77.00	2.36	NA	28.34
February 4, 2024	6.3	94	64.91	2.08	4.21	34.00
March 22, 2024	5.1	114	86.14	1.83	3.74	40.00
April 15, 2024	5.4	97	74.15	1.86	2.48	39.00
July 10, 2024	5.5	92	81.73	1.82	NA	40.00

HbA1c, hemoglobin A1c; FBS, fasting blood sugar; eGFR, estimated glomerular filtration rate; EPI, Epidemiology Collaboration; NA, record not available.

2025. The patient suffered an intestinal obstruction with perforation in March 2025 due to intestinal metastasis and succumbed to the complications. The patient continued with the carnivore diet and maintained remission of his DM and hypertension until his demise.

DISCUSSION

No reports from India have shown remission from DM and hypertension using the carnivore diet. Type 2 DM has been well known as a disease associated with carbohydrate overconsumption [8,9]. The diabetic diet our patient was advised to consume was very high in carbohydrates and was obviously counterproductive. This case highlights the inefficacy of standard diabetic diets in reversing DM. The patient suffered from various complications of DM throughout the years, such as early onset retinopathy, cataract, kidney disease, and renal cell carcinoma.

Ketogenic and very low carbohydrate (< 50 g of carbohydrates/day) diets have been shown to be effective in reversing DM [10]. In fact, the Prospective Urban Rural Epidemiology study highlighted a significant association between high carbohydrate intake and mortality, whereas higher intake of fats was associated with lower mortality [11]. Unwin et al. [12] found that patients with DM who selected a low carbohydrate diet achieved a 77% remission rate in < 1 year. Moreover, a randomized study by Saslow et al. [13] reported greater HbA1c reductions in the very low carbohydrate group compared to the moderate carbohydrate, calorie restricted, low fat groups. Furthermore, Kelly et al. [6] recommended early deprescription of DM medications, such as insulin, sulphonylureas, and sodium-glucose cotransporter inhibitors. In line with this recommendation, our patient was similarly tapered off his medications in approximately 3 months.

Ketogenic diets have been shown to ameliorate schizophrenia, reverse metabolic dysfunction-associated liver disease, reduce behaviors related to autism, promote pleitrophic effects to positively influence the cardiovascular systems, provide therapeutic benefits against cancer, and treat epilepsy [7,14-18].

Carnivore diets, however, have yet to be extensively studied. Norwitz et al. [19] reported a series involving 10 patients with inflammatory bowel disease who showed a positive clinical response to mostly carnivore diets. In another series, patients suffering from anorexia not responding to standard treatment achieved 1 to 5 years of remission, weight gain, reduced anxiety, and improved mental well-being while on an animal-based ketogenic diet [20]. Another study involving 2,029 respondents consuming a carnivore diet (> 85% animal products daily) for 14 months reported reductions in median HbA1c, body mass index, and diabetes medication use [21]. A recent meta-analysis of randomized trials reported that carbohydrate restricted diets significantly improved glycemic control, decreased hepatic stress, and increased renal function particularly in females, obese people, and those suffering from type 2 DM. In fact, replacing carbohydrates with a combination of fats and protein yielded even better outcomes [22].

The success of any diet or lifestyle change depends on adherence and consistency. Our patient showed consistent efforts to stay on the carnivore diet. Reversing diabetes and hypertension for 20 years only added to his motivation. Research suggests that the carnivore diet may induce some B vitamin and vitamin C deficiencies, but the requirements for the same is reduced for people who are on this diet [23]. Another interesting finding in our case was the lack of a drastic deterioration in kidney function while on a high fat and protein diet, which contradicts beliefs that higher protein diets decrease renal function.

Unique aspects

India has a largely carbohydrate-consuming population. In their recent INDIAB survey, Anjana et al. [24] reported that most Indians consuming 64% of their daily calories from carbohydrates, with 83% of the participants having at least one metabolic risk factor. To the best of our knowledge this has been the first case from India reporting complete remission of longstanding DM and hypertension using a high fat and moderate protein carnivore diet. No major renal impairments occurred while on this diet. In fact,

we noticed an improvement in the patient's eGFR. This finding is consistent with studies reporting that high intake of dietary protein had no detrimental effects on eGFR [22,25,26]. The remission of DM and hypertension in our patient was maintained despite concurrent management of the renal cell carcinoma, suggesting that the diet positively affected metabolic parameters but not cancer progression.

We acknowledge that the long-term safety profile of the diet remains unknown. Given that this report involves a single case, no generalizations can be established. As such, further studies are needed to clarify whether a nutrient dense carnivore diet can be a potent and safe strategy for the remission of DM. Overall, we believe that physicians and nutritionists alike should be more prudent when treating patients with DM and recommend the complete elimination of carbohydrates.

ARTICLE INFORMATION

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Authors' contributions
All the work was done by Ankur Verma.

Conflicts of interest
None.

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Data availability
Data of this research are available from the corresponding author upon reasonable request.

REFERENCES

1. International Diabetes Federation. IDF diabetes Atlas. 11th ed. International Diabetes Federation; 2025.
2. Mohan V, Bhavadharini B, Mukhopadhyay S, et al. Diabetes in pre-independence India: rediscovering a forgotten era. J Assoc Physicians India 2021;69:11-2.
3. Osler W. The principles and practice of medicine. D. Appleton and Company; 1912.
4. Rollo J. Account of two cases of diabetes mellitus, with remarks. Ann Med (Edinb) 1797;2:85-105.
5. American Diabetes Association Professional Practice Committee. 5. Facilitating positive health behaviors and well-being to improve health outcomes: standards of care in diabetes-2025. Diabetes Care 2025;48(1 Suppl 1):S86-127.
6. Kelly T, Unwin D, Finucane F. Low-carbohydrate diets in the management of obesity and type 2 diabetes: a review from clinicians using the approach in practice. Int J Environ Res Public Health 2020;17:2557.
7. Newiss M. Case report: remission of schizophrenia using a carnivore ketogenic metabolic therapy with nutritional therapy practitioner support. Front Nutr 2025;12:1591937.
8. Hu FB, Manson JE, Stampfer MJ, et al. Diet, lifestyle, and the risk of type 2 diabetes mellitus in women. N Engl J Med 2001;345:790-7.
9. Bonsembiante L, Targher G, Maffeis C. Type 2 diabetes and dietary carbohydrate intake of adolescents and young adults: what is the impact of different choices? Nutrients 2021;13:3344.
10. Feinman RD, Pogozelski WK, Astrup A, et al. Dietary carbohydrate restriction as the first approach in diabetes management: critical review and evidence base. Nutrition 2015;31:1-13.
11. Dehghan M, Mente A, Zhang X, et al. Associations of fats and carbohydrate intake with cardiovascular disease and mortality in 18 countries from five continents (PURE): a prospective cohort study. Lancet 2017;390:2050-62.
12. Unwin D, Delon C, Unwin J, Tobin S, Taylor R. What predicts drug-free type 2 diabetes remission? Insights from an 8-year general practice service evaluation of a lower carbohydrate diet with weight loss. BMJ Nutr Prev Health 2023;6:46-55.
13. Saslow LR, Daubenmier JJ, Moskowitz JT, et al. Twelve-month outcomes of a randomized trial of a moderate-carbohydrate versus very low-carbohydrate diet in overweight adults with type 2 diabetes mellitus or prediabetes. Nutr Diabetes 2017;7:304.
14. Watanabe M, Tozzi R, Risi R, et al. Beneficial effects of the ketogenic diet on nonalcoholic fatty liver disease: a comprehensive review of the literature. Obes Rev 2020;21:e13024.
15. Li Q, Liang J, Fu N, Han Y, Qin J. A ketogenic diet and the treatment of autism spectrum disorder. Front Pediatr 2021;9:650624.
16. Dynka D, Kowalcze K, Charuta A, Paziewska A. The ketogenic diet and cardiovascular diseases. Nutrients 2023;15:3368.
17. Hwang CY, Choe W, Yoon KS, et al. Molecular mechanisms for ketone body metabolism, signaling functions, and therapeutic potential in cancer. Nutrients 2022;14:4932.
18. Williams TJ, Cervenka MC. The role for ketogenic diets in epilepsy and status epilepticus in adults. Clin Neurophysiol Pract 2017;2:154-60.
19. Norwitz NG, Soto-Mota A. Case report: carnivore-ketogenic diet for

the treatment of inflammatory bowel disease: a case series of 10 patients. Front Nutr 2024;11:1467475.
20. Norwitz NG, Hurn M, Forcen FE. Animal-based ketogenic diet puts severe anorexia nervosa into multi-year remission: a case series. J Insul Resist 2023;6:a84.
21. Lennerz BS, Mey JT, Henn OH, Ludwig DS. Behavioral characteristics and self-reported health status among 2029 adults consuming a "carnivore diet.". Curr Dev Nutr 2021;5:nzab133.
22. Feng S, Liu R, Colwell B, Chung S, Barry A, Wang H. Carbohydrate-restricted diet types and macronutrient replacements for metabolic health in adults: a meta-analysis of randomized trials. Clin Nutr 2025;54:27-41.
23. Goedeke S, Murphy T, Rush A, Zinn C. Assessing the nutrient composition of a carnivore diet: a case study model. Nutrients 2024;17:140.
24. Anjana RM, Sudha V, Abirami K, et al. Dietary profiles and associated metabolic risk factors in India from the ICMR-INDIAB survey-21. Nat Med 2025;31:3813-24.
25. Truche AS, Bailly S, Fabre O, Legrand R, Zaoui P. A specific high-protein weight loss program does not impair renal function in patients who are overweight/obese. Nutrients 2022;14:384.
26. Devries MC, Sithamparapillai A, Brimble KS, Banfield L, Morton RW, Phillips SM. Changes in kidney function do not differ between healthy adults consuming higher-compared with lower- or normal-protein diets: a systematic review and meta-analysis. J Nutr 2018;148:1760-75.