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BRINGING CLINICIANS TOGETHER TO DISCUSS CURRENT DRUG THERAPY

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The following succinct analysis appeared in *Pharmacist's Letter*. Based on vol. 37. No. 10

KIDNEY DISEASE

Kerendia (finerenone) will be a new Rx for patients with chronic kidney disease (CKD) due to type 2 diabetes.

It's the first "nonsteroidal mineralocorticoid receptor antagonist"...and is approved to slow kidney disease progression and improve CV outcomes in these patients.

Kerendia is thought to limit fibrosis and inflammation in the kidneys and heart...by blocking effects of aldosterone.

Think of spironolactone or eplerenone as working similarly. But they're steroidal...and don't have evidence of improved CKD outcomes.

Adding once-daily *Kerendia* to max ACEI or ARB doses slows kidney disease progression in about 1 in 30 patients over 2.5 years...mostly due to less risk of significant eGFR decline, not kidney failure or death.

It also reduces risk of CV events in about 1 in 56 patients... likely due to reducing heart failure hospitalizations.

But think of *Kerendia* as a "niche" med...and weigh downsides.

It causes hyperkalemia in up to 1 in 11 patients...is not recommended in eGFR below 25 mL/min/1.73 m2...and costs about $570/month.

Instead, continue to first emphasize optimizing BP and glucose control...and maximizing ACEI or ARB doses.

If patients with CKD due to type 2 diabetes need a metformin add-on, consider an SGLT2 inhibitor (*Jardiance*, etc) or possibly a GLP-1 agonist (*Victoza*, etc)...especially for those at high CV risk.

Point out that these meds help protect the kidneys...improve CV outcomes...and lower glucose. *Kerendia* doesn't lower glucose.

Keep in mind, SGLT2 inhibitors have more evidence for CKD than GLP-1 agonists.

Save *Kerendia* as a last resort to slow progression of kidney disease in patients with type 2 diabetes...when an SGLT2 inhibitor or GLP-1 agonist isn't an option.

Don't recommend ADDING *Kerendia* to these meds for CKD...there's no evidence of additional benefit yet.

Advise monitoring potassium similar to an ACEI or ARB...at baseline and within 4 weeks of starting *Kerendia* or adjusting the dose.

See our chart, *Slowing Progression of Kidney Disease in Patients With Diabetes*, for more on treatment and *Kerendia*'s role.

(For more on this topic, see Clinical Resource #371006 at PharmacistsLetter.com.)

Bakris GL, Agarwal R, Anker SD, et al. Effect of finerenone on chronic kidney disease outcomes in type 2 diabetes. N Engl J Med 2020;383:2219-29.

See LEADER NOTES for answers to discussion questions.

DISCUSSION QUESTIONS

OVERVIEW OF CURRENT THERAPY

1. **What is known about treating diabetic kidney disease?**

ANALYSIS OF NEW GUIDELINE

2. **What type of study was this? How were the patients selected for inclusion?**

3. **How were the stud groups defined?**

4. **How were the outcomes evaluated?**

See LEADER NOTES for answers to discussion questions.

5. **What were the outcomes of this trial?**

6. **What were the strengths and weaknesses of this trial?**

7. **Were the results expressed in terms we care about and can use?**

HOW SHOULD THE NEW FINDINGS CHANGE CURRENT THERAPY?

8. **Do the results change your practice? How?**

APPLY THE NEW FINDINGS TO THE FOLLOWING CASE

TM is a 69-year-old Hispanic male who presents to your office for follow-up of hypertension and diabetes. His blood pressure is 134/76 mmHg, pulse 81. His most recent lab work was over a year ago and is notable for an elevated creatinine of 1.4 mg/dL, eGFR 47 mL/min/1.73 m2, and hemoglobin A1C of 8.3%. He is adherent to valsartan 320 mg daily, chlorthalidone 25 mg daily, and metformin 1g twice daily. He has worked hard over the last year to lose weight and improve his diet.

See LEADER NOTES for answers to discussion questions.

9. **What lab work should you consider for TM? What stage CKD does he have?**

You obtain additional labs. TM's creatinine remains elevated at 1.7 mg/dL and his spot urine albumin-to-creatinine ratio is 285 mg/g. His A1C returns at 6.8%. The rest of his lab work is unremarkable.

10. **What is TM's blood pressure goal? What medication adjustments would you recommend to improve his CV outcomes?**

You discuss TM's lab work and suggest adding aspirin 81 mg daily and atorvastatin 80 mg daily to lower his cardiovascular risk. TM is agreeable to this but is most concerned about his worsening renal function, as his father was on dialysis prior to his death. TM is interested in anything he can do to reduce his risk of needing dialysis.

11. **In addition to reinforcing BP and glucose control, how should you counsel TM on reducing his risk of kidney failure?**

You discuss that some meds for diabetes are shown to improve outcomes in patients with CKD. However, further glucose lowering isn't necessary for TM since his A1C is at goal.

You also bring up that finerenone is an option, and is shown to slow the progression of kidney disease in about 1 in 30 patients and reduce the risk of CV events in 1 in 56 patients with diabetic kidney disease. However, it can also cause high potassium in about 1 in 11 patients and costs $570/month if TM has to pay out of pocket.

See LEADER NOTES for answers to discussion questions.

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Additional Pharmacist's Letter Resources available at PharmacistsLetter.com

Chart, Slowing Progression of Kidney Disease in Patients with Diabetes. Pharmacist's Letter/Prescriber's Letter. October 2021.
Checklist, Chronic Kidney Disease Checklist. Pharmacist's Letter/Prescriber's Letter. August 2018.
Chart, Diabetes Medications and Cardiovascular Impact. Pharmacist's Letter/Prescriber's Letter. October 2021.
Chart, Drugs for Type 2 Diabetes. Pharmacist's Letter/Prescriber's Letter. December 2020.
Toolbox, Improving Diabetes Outcomes. Pharmacist's Letter/Prescriber's Letter. March 2019.
Chart, Comparison of GLP-1 Agonists. Pharmacist's Letter/Prescriber's Letter. August 2019.
Chart, Hypertension in Patients With Diabetes. Pharmacist's Letter/Prescriber's Letter. May 2018.
Algorithm, Monitoring ACEIs and ARBs. Pharmacist's Letter/Prescriber's Letter. May 2021.

See LEADER NOTES for answers to discussion questions.