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Impact of Finerenone on eGFR Slope by Baseline Albuminuria in FINEARTS-HF

Welcome to DataPulse from ERA 2025. This activity, titled “Impact of Finerenone on eGFR Slope by Baseline Albuminuria in FINEARTS-HF” is provided by Medcon International.

Dr. McCausland:
Hello. Welcome to this presentation from the ERA 2025 here in Vienna. My name is Finnian McCausland, and I'm delighted to present the results of data that we just presented here at ERA, and this was examining the effects of finerenone on eGFR slope across different categories of baseline UACR and eGFR among participants of the FINEARTS-Heart Failure trial.

So just by way of background, finerenone did not modify the risk of kidney outcomes or eGFR slope among participants of FINEARTS-Heart Failure. And FINEARTS-Heart Failure was a trial of patients with heart failure with preserved ejection fraction. They were overall at relatively low risk of kidney adverse events. They had very modest levels of proteinuria, with a median albumin-to-creatinine ratio of around 18 mg/g.

Therefore, we asked the question, because there was a nice spread of patients across the baseline categories of uACR, would this potentially modify the treatment effect of finerenone versus placebo on the eGFR slope?

So to do this, we analyzed different categories of baseline uACR according to standard clinical categories that you're familiar with: less than 30 mg/g, 30 to 300, or 300 or greater. And then we also looked at eGFR categories of less than 45 mL/min, 45 to 60, or greater than 60 mL/min. We then examined these as potential modifiers of the treatment effect of finerenone versus placebo on the eGFR slope in both the total slope, acute, and chronic. And what we found was, across all of the data, that finerenone caused an acute initial decline in eGFR. This was completely expected based on prior data and also based on the pharmacological activity of the medication itself.

What was probably most interesting was when we looked at the chronic slope—this was from 3 months out towards the end of the study—we found that there was some evidence of statistical heterogeneity across the baseline categories of UACR. The P value for interaction was 0.09, and so this certainly is a hint towards heterogeneity, but is by no means conclusive and probably somewhat limited by the smaller number of patients in the higher UACR subgroup.

But what we found was that for those with a UACR of more than 300 mg/g, there appeared to be a clinically significant and statistically significant differential treatment effect for finerenone versus placebo in that higher category. And this was a difference of 1.2 mL/min/year in the chronic eGFR slope in favor of the finerenone group. We did not find any evidence for a statistical heterogeneity across the baseline categories of eGFR.

So to summarize our findings in the FINEARTS-Heart Failure trial, again, a trial of patients with heart failure and preserved ejection fraction, there was some suggestion of differential treatment effects for those with a higher baseline urine albumin-to-creatinine ratio, above 300 mg/g. This is an important finding, we think, because, number one, it highlights the prognostic significance of urine protein, urine albumin in particular, in patients with heart failure. And number two, it may have implications for clinical trial design, particularly for those that are considering eGFR slope as an outcome. So if one is considering enrichment for trial design, looking at eGFR slope as an outcome, it is probably better to consider higher levels of urine albumin-to-creatinine ratio in preference for lower levels of eGFR.

So that's a summary of our findings from ERA 2025 in Vienna. My name is Finnian McCausland. Thank you very much for listening.

Thank you for listening to this DataPulse from ERA 2025. This activity is provided by Medcon International Thank you for listening.