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Nonsteroidal MRAs: The CKD/T2D Advantage

Announcer:
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Dr. McMurray:
Hello, I'm John McMurray, and I'm here with my colleague and friend, Pardeep Jhund. We're both from the University of Glasgow and we're going to talk about the use of finerenone in practice.

So, Pardeep, we've already heard a bit about finerenone and how it compares to the older steroidal mineralocorticoid receptor antagonists. I'd like to talk about how we might use finerenone and the evidence that we have for doing that. Do you want to tell us a little bit about what we know about the use of this new agent?

Dr. Jhund:
Yes, I'd love to, and maybe I can illustrate that with a case. And here, you can see a case of a 78-year-old man who has a history of type 2 diabetes and chronic kidney disease. You can see his physical exam there, his blood pressure and his BMI, and you can see the medications that he's taking, which are kind of standard for the patient and type 2 diabetes these days. He's on some antihypertensive medications, he's on amlodipine, he's also on ramipril as well. And he's taking metformin, a very commonly used first-line drug for diabetes. And over on the side there, you can see his labs, his laboratory test results, his HbA1c is 6.3%, potassium is 5 mmol/L, and his creatinine works out an eGFR of 58.

You can see his urinary-to-albumin creatinine ratio is 283 mg/g, and those put him there on the KIDIGO guidance, when you cross-tabulate UACR against eGFR, right there, right in the middle of this risk spectrum of the patient with chronic kidney disease. And then finally, his NT-proBNP is 1,108 pg/mL. So the question then becomes what do we do with this patient after a little bit of time? How do we start him? And I think this patient is an ideal candidate for finerenone, as you said.

Dr. McMurray:
And why is that? So why finerenone, firstly? And secondly, why not, for example, spironolactone?

Dr. Jhund:
Well, we have really good data about the use of finerenone in a patient just like this. We have 2 large randomized trials, morbidity and mortality trials, looking at important endpoints for this patient: FIDELIO-DKD and FIGARO-DKD, and both of them showed that the patients like him, randomized to finerenone, did much, much better in terms of outcome, reducing the risk of kidney progression and of cardiovascular events.

Dr. McMurray:
Very recently we've learned that SGLT2 inhibitors are tremendously useful in these patients. Do we have evidence that finerenone actually adds to the benefit of SGLT2 inhibitors?

Dr. Jhund:
Yes. It's a really great question, really important for clinicians and the patients. So we have great data from the combination of all the finerenone trials. Nearly 19,000 patients that we combined from FIGARO, FIDELIO, FINEARTS-HF, and we looked at all of the patients with type 2 diabetes in those trials.

Dr. McMurray:
What did you call that meta-analysis?

Dr. Jhund:
We called that the FINE-HEART meta-analysis, and what we can see from that is that in the patients who are receiving an SGLT2 inhibitor, they had as much benefit as the patients who were not receiving an SGLT2 inhibitor. It was additive, going back to your question. So the patients who were already on an SGLT2 inhibitor gained by going onto finerenone just as much as the patients who were not on the SGLT2 inhibitor. And we saw the same thing with the GLP-1 receptor agonist.

So I think that's really great news for our patients out there with type 2 diabetes, chronic kidney disease, because it means we have something more to give them that's going to reduce their very high risk of cardiovascular and kidney events.

Dr. McMurray:
Right. So the take-home message from this is, in patients with chronic kidney disease and type 2 diabetes, we now have multiple treatments that reduce both their cardiovascular and their kidney risk. And one of those treatments is finerenone.

Dr. Jhund:
That's correct.

Announcer:
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