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Summarizing multidisciplinary strategies: Where do we go from here?

Dr. Savarese:
The GUARDIAN-HK recommendation, I think, summarize the take-home messages for the lecture you have been listening today. And this recommendation, as I previously mentioned, are related to duty of care, identifying patients' risk of hyperkalemia recurrence, and managing the risk of hyperkalemia recurrence. What is important to remember is that reducing the risk of recurrence should be standard practice for the management of hyperkalemia regardless of the settings, so cardiology, CKD departments, and so on. And each physician meeting patients with hyperkalemia or at risk of hyperkalemia is responsible for actually taking care of this patient and making an assessment of the risk of recurrency in these patients.

And also, very importantly, each medical encounter should be actually an opportunity for optimizing RAASi therapy in these patients, even in the context of a hyperkalemic event, because we learned that there are treatments able to support RAASi implementation even in patients at risk of hyperkalemia. Long-term conditions, such as CKD, cardiovascular disease, and type 2 diabetes, are irreversible causes of hyperkalemia, but we should not forget that RAASi and MRA, although you might perceive they can be discontinued and, therefore, they are not irreversible risk factor, actually, they are. Because whether we withdraw this treatment, we increase the risk of mortality in our patients, so we should definitely avoid that. And in the future, we are developing a risk stratification tool in order to better predict risk of recurrency in patients with a hyperkalemic event.

When it comes to the management of these patients, the initial aim when we meet the patients with hyperkalemia is, of course, to normalize potassium levels and correct reversible precipitating factors for hyperkalemia. And whether none of this is identified, actual treatment for prevention of recurrency should be initiated. And the risk of recurrency of hyperkalemia should be actually managed without withdrawing RAASi or down-titrating RAASi because, as we say, we have treatment which allow us to do so. And unless the cause of acute hyperkalemia can be reverted, treatment for hyperkalemia has to be considered definitive.

Thank you very much for your attention.