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Future Directions in Managing Hyperkalemia in CKD and HF

Announcer:
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Dr. Butler:
This is CME on ReachMD, and I'm Dr. Javed Butler. And here with me today is Dr. James Burton. Jim, welcome to the program.

Dr. Burton:
Hi, Javed, nice to be back.

Dr. Butler:
Okay, so I would really like to get your opinion. When you are treating patients with, say, heart failure or CKD, are you worried about hyperkalemia? And if you are, how do you manage that risk both at an individual level and at a system level?

Dr. Burton:
Well, the answer is, we're all worried about hyperkalemia. We're told at medical school, in our training that hyperkalemia kills people, right? We should all be thinking about hyperkalemia.

I guess my one reflection, here we are, I'm a nephrologist and you're a cardiologist and we've done these things before, and one person's perception of hyperkalemia and risk is not the same as someone else's. Okay? And I think we probably need to be thoughtful about that. Because I've often been in my clinics, and someone has said to me, ‘Should we start someone on an MRA or RAASi therapy?’ And I say, yeah, it's fine. The potassium is only 5.2 and we can be relaxed about it. But we can't. We can't be like that actually, because we've all got to be coming from the same page. And if a guideline says you shouldn't start spironolactone if the potassium is 5, then it doesn't help that my level of risk and my perception around hyperkalemia is different to someone else's. So the first thing I would say, Javed, is that we should all be on the same page with what that risk means and what hyperkalemia means.

And then the second thing I would say is, what do I do about that? And how do I manage that from a clinician point of view and a kind of system perspective? That's a great question. And the answer is, I do that with the team of people around me so that everyone feels comfortable, and everybody feels empowered, and the patient’s involved in that as well. Because the key is to make sure that the individual in front of us with diabetes, maybe with CKD and heart failure, who's at risk of hyperkalemia and many cardiovascular events and other things, that they're on goal-directed medical therapy. They're on the right therapy at the right dose, and that if we need to manage hyperkalemia as a facilitator for getting them on their goal-directed medical therapy, that's really important. And that we should be using novel potassium binders in that.

And the last thing to say that we know—and guidelines tell us—we shouldn't need the American Heart Association and KDIGO to tell us to work together well, but it's really important that they do do that. And they say, come on, get on with your cardio-renal clinics, use your cardio-renal-metabolic clinics to work together. Because we know from the literature that working together can reduce progression to end-stage kidney failure, take up of dialysis, hospitalizations for heart failure, and mortality. And those are outcomes that are important for the people that we look after, but they're also really important for our health systems. Because this tide of dialysis and hospitalizations for heart failure, we're just not going to be able to afford that.

Dr. Butler:
Your comments so resonate with me. Look, there's black and white, right? I mean, none of us will sit tight on a potassium of 6.0. Okay, we all get it. But whether your threshold is 5.2 and my threshold is 4.9 or whatever it is, just telling people to get over their fears is not going to work.

And remember that these fears are not completely unfounded, because, sure, so we have guidelines saying not to give MRA if your GFR is less than 30. Okay, fine. But if your GFR is 35, if you have an older person, if you have a person who lives far away, if a person cannot come to the clinic for close follow-up, if there is no home health available, if they have multiple comorbidities, they have past history of hyperkalemia—I mean, we can go on and on as to what actually shapes clinicians' behavior, and these things are important.

But at the end of the day, we cannot have our patients not get the best medical therapy, right? All of these things that I just said are true, and we should be pretty sympathetic towards clinicians and why they worry about hyperkalemia. Most of the time, it's really an appropriate worry. But the answer to that worry is not to stop medical therapy, because at the end of the day, people have CKD, people have diabetes, people have high blood pressure, people have heart failure, and all of these things put patients at higher risk of dying. And the only way—the only real patient-centered care—is to give good medical therapy to stop the progression of the disease. And the only way you will do that is by giving medical therapy.

Now, this used to be a pretty difficult discussion a decade ago, right? Because we did not have good therapies. But in this day and age, when we have good potassium binders with long-term safety, tolerability, and efficacy data—that, boy, I mean, other than accessibility, there's really no reason why we should not be using these potassium binders to optimize the care of these patients.

And you make some really good points about multidisciplinary care. But I think all of us should take the responsibility that either we initiate the therapy, or if you're uncomfortable, then refer the patient to a specialist who would feel comfortable. But not giving patients the medical therapies is really not an option.

Dr. Burton:
I was just going to say that comfort zone, actually. And the one thing I would say is that you know I've been to see people with heart failure and said, 'Come on, get the diuretics up. Don't worry about the creatinine. Offload their fluid, because otherwise they'll be back in in a couple of weeks. Don't worry about the creatinine.' And similarly, people have come to me and said, 'Jim, come on, you know get them on their pillars of heart failure management,' because we know that people with CKD are not treated the same as people without when it comes to their cardiovascular disease. So we definitely bring our comfort zones and our lenses, and ultimately, working together like that is going to improve outcomes for all of our patients.

Dr. Butler:
Could not agree with you more. Thank you so much.

Announcer:
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