Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/clinical-practice/cardiology/finerenone-in-ckm-disease-and-hfpef-key-takeaways-from-esc-hf/49255/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Finerenone in HFpEF: Key Insights From ESC HF

Annouuncer:
Welcome to DataPulse from ESC Heart Failure 2026 on ReachMD. This activity, titled "Finerenone in HFpEF: Key Insights From ESC HF is provided by **Medcon International**.

Dr. Ostrominski:
Hello from ESC Heart Failure here in Barcelona, Spain. I'm Dr. John Ostrominski, and today I'll be reviewing data that was recently presented at the congress, specifically focusing on 2 important analyses related to finerenone in individuals either with heart failure or with cardiovascular, kidney, and metabolic disease.

The first of which actually concerns finerenone and its potentially broader effects in a broader CKM population, specifically focused on this important outcome of all-cause morbidity in this population. And the importance of this analysis gets to the notion that individuals with cardiovascular, kidney, and metabolic conditions, we know that they suffer from high risks of cardiovascular disease, but we also know that they might suffer high risks of hospitalization due to a wide array of other causes.

And other kind of important foundational therapies in this space, like SGLT2 inhibitors, as an example, have also shown potential benefits on this broader question of all-cause morbidity, specifically all-cause hospitalization. But whether or not finerenone actually can impact all-cause hospitalization in an individual population at risk for broad forms of cardiovascular, kidney, and metabolic disease really has not been rigorously evaluated.

And so in this analysis of FINE-HEART, which incorporated the totality of phase 3 data of finerenone versus placebo, including individuals with heart failure or with chronic kidney disease and type 2 diabetes, what we ultimately see is actually over a median follow-up of less than 3 years, half of that population of nearly 19,000 individuals had at least 1 hospitalization, highlighting this important risk of hospitalization for any cause.

In addition to that, finerenone modestly but substantially reduced the risk of all-cause hospitalization by around 5%. But because that absolute risk was so high, the number needed to treat over 4 years was around 47. So fairly important magnitude of benefit with respect to absolute benefit. These benefits on all-cause hospitalization were additionally consistent irrespective of kidney function, irrespective of age, and irrespective of background CKM conditions.

The other important analysis, now focusing specifically on FINEARTS, a population of symptomatic chronic heart failure with mildly reduced or preserved ejection fraction, was also getting at a broader theme of undiagnosed chronic kidney disease. Now, we know that chronic kidney disease is an important modifier of risk in this population and is also modifiable with targeted therapies.

But one of the major gaps, though, in chronic kidney disease care are the substantial gaps in recognition and marked gaps in screening. Even in high-risk individuals like those with heart failure, CKD is profoundly underdiagnosed and undertreated.

And so in this FINEARTS population, we actually endeavored to understand the prevalence of undiagnosed CKD. So using actually investigator-reported medical histories and systematic screening with both urine albumin-to-creatinine ratio, a measure of kidney damage, and eGFR, a measure of kidney filtration function, what we ultimately found is actually nearly half of the FINEARTS population

had undiagnosed CKD, and around 1 in 4 had diagnosed CKD, such that when considering both diagnosed and undiagnosed CKD, it was 2 in 3 individuals in FINEARTS.

We additionally found that undiagnosed CKD was associated with a markedly higher risk of adverse cardiovascular outcomes compared with those without CKD and an intermediate risk as compared to those with diagnosed CKD.

We additionally found that individuals either who were women, who actually had diabetes, or at older age were more likely actually to have undiagnosed CKD, getting at the importance of these kind of treatment and diagnosis gaps.

And then lastly found that the benefit of finerenone on adverse cardiovascular outcomes was consistent even among those with established CKD, either diagnosed or undiagnosed.

And so to kind of bring this together into a single synthesis, these analyses really highlight the importance of broader risks simply beyond cardiovascular disease and encourage cardiologists, including heart failure cardiologists, to really think beyond the heart when modifying total measures of health.

And so with that, from ESC Heart Failure 2026, I'm Dr. John Ostrominski, and thank you for listening.

Announcer:
Thank you for listening to this DataPulse from ESC Heart Failure 2026 on ReachMD. This activity is provided by **Medcon International**. Thank you for listening.