Transcript Details

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Released: 07/22/2025
Valid until: 07/22/2026
Time needed to complete: 15 Minutes

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Optimize Outcomes in CKD & T2D: A Practical Approach to Initiating and Monitoring Combination ns-MRA & SGLT2i Therapy

Announcer:
Welcome to CE on ReachMD. This activity, titled “Optimize Outcomes in CKD & T2D: A Practical Approach to Initiating and Monitoring Combination non steroidal MRA & SGLT2 inhibitor Therapy” is provided by Medcon International.

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Dr. Mottl:
Hello. Thank you for joining us. This is CME on PACE CME and ReachMD. I'm here with Dr. Christoph Wanner, who is a nephrologist in Germany, and I'm Amy Mottl. I'm a nephrologist in the United States. And we've just received the results of the CONFIDENCE trial, which is a clinical trial looking at finerenone and empagliflozin started simultaneously versus empagliflozin or finerenone alone. And these results showed a significant decrease in albuminuria, more than 50% decline. And we are here to discuss a case of Dr. Wanner’s to illustrate how we're applying this trial, as well as all of the trials in the past, to take care of our patients with diabetes and chronic kidney disease.

So good to see you, Christoph. Do you have a case we could talk about?

Dr. Wanner:
Oh, yes. You mentioned CONFIDENCE, but I brought a case which I started to handle 3 years ago. So we may apply, later on, CONFIDENCE to my case. So it's a 67-year-old male with type 2 diabetes, and he was referred to me 3 or 4 years ago with an eGFR of 61. And the question was: There are modern treatments out there. Do you recommend SGLT2 inhibitor at this time?

So I did UACR which was missing, and I found 848 mg/g albumin. And clearly, despite relatively good preserved kidney function, he had diabetic kidney disease. So blood pressure was 145, BMI 32, LDL cholesterol 98 mg/dL, and a moderately well-controlled hemoglobin A1c.

So this was, you can say, suboptimal treatment, but the patient told me, “Wait a minute. I take already 7 pills per day.” I was looking at his medication and it was ramipril, amlodipine, simvastatin, I did not understand the aspirin, was metformin, and the DPP4 inhibitor. And I felt, yes, this patient requires an SGLT2 inhibitor.

So I gave it to him and asked him to come back a couple of months later. And actually, he missed the first appointment. Six months later, he had concerns. His eGFR dropped to 49 mL, but UACR also dropped by 30%, and his LDL cholesterol was better. Blood pressure was better.

And there was a general practitioner who also gave him a diuretic, eliminated aspirin to handle the 7 pills. So I felt this now deserves a new medication in addition to SGLT2 because UACR was still 500 mg/g.

So finerenone came up. I prescribed this to him and asked him to come back, and again, 6 months later, eGFR 42. Expected, because these are hemodynamic-acting drugs, which I accept, totally, the decline in eGFR because they are better off in the long-term run. The UACR was down to 200 and blood pressure was better. LDL cholesterol. So I was excited.

And since the patient had so much compliance, I added semaglutide, and then, really, I was really flashed. He had 90 mg UACR, eGFR didn't change, blood pressure optimal. Body mass index, for the first time in his life, he lost weight and it looked like miraculous treatment.

I can tell you the reality. It is my best patient. He did what I thought should be appropriate. I had a couple of more telephone calls to the GP to calm him down, and the diabetologist, so it was a lot of work. But finally, with this new modern treatment, you can do a proper control of the cardio-kidney-metabolic risk profile.

Dr. Mottl:
Yeah. No, that is a perfect case, Christoph. And there's a number of things, I think, to call out about that case. First of all, when you initially saw him, he had not had a UACR done, it sounds like. And you and I both know that albuminuria screening is far underappreciated in general practice, and even amongst diabetologists. And across the board, ACR screening annually for people with diabetes is recommended.

Dr. Wanner:
I stick to this. I know that doctors don't do it in general practice. In some countries, even absent. But I think, slowly, cardiologists will help to screen their heart failure patients with CKD, and slowly, it's improving.I think we have to show the world that this is important. It tells us the damage and how fast the patient is progressing. That's UACR.

Dr. Mottl:
Yes, and it's great because it's a target for therapy, right? So you started adding on additional therapies because the ACR was still very elevated.

Dr. Wanner:
So in such cases where you have 800 mg, and this is high risk, you need more than 1 treatment. Yeah. And you have to add.

So I must say it took me 2 years to really fulfill and complete this task. I lost a lot of time, and today – when I look at the modern approach to this patient. So maybe we can do better in the future.

Dr. Mottl:
Right. And I think your comment about calming down some of the other physicians is definitely something we should talk about because multidisciplinary care is critical and having all providers on board. But I think the eGFR drop makes a lot of people, and definitely patients, very concerned. So what is your approach for talking to people about that?

Dr. Wanner:
I prepare them before. Don't worry. Because when your kidney is running on a better energy level, when hyperfiltration goes away, you are better off. We give away a little bit of this eGFR, but then in the long run, it's so of advantage. So I don't care anymore and I'm very provocative sometimes. I tell my GPs don't measure creatinine anymore because nothing happens. It is just stabilizing over time and the meta-analysis in 25,000 people, we just heard recently from the Oxford Group, assures you that we may even recommend to change the package insert to regulators because they are so safe in the long run. So we have more and more experience with SGLT2 inhibitors and other drugs that we can be more liberal.

Dr. Mottl:
For those just tuning in, you're listening to CME on PACE CME and ReachMD. I'm Dr. Amy Mottl, and I'm here today with Dr. Christoph Wanner. We're discussing the optimal treatment approach for patients with CKD and type 2 diabetes.

Dr. Wanner:
We just saw the CONFIDENCE results just published in The New England Journal, also. And we saw that an SGLT2 inhibitor declines the eGFR by 4. And if you add finerenone, you are by -6 mL/min. That's the average.

I can understand that you have seen patients occasionally with more, with 20, and even this case here, dropped from 61 to 42. This is a substantial amount. But he was hyperfiltering. He was running on less nephrons, and therefore, we know that we should keep treating. Don't stop. And then you will see stabilization over time, which is perfect.

Dr. Mottl:
And with CONFIDENCE now showing that it's not only effective but safe to start these medications together, as you and I know our cardiology counterparts do all the time in goal-directed therapy. It's something that I now feel very comfortable doing as well. There was a slightly larger decrease in blood pressure, but to me, that is actually a benefit because our patients are often on multiple antihypertensives, and it's an opportunity to stop other blood pressure medicines that don't necessarily have the same cardio-kidney-metabolic benefits as do SGLT2 inhibitors and finerenone. So I'll stop somebody's amlodipine in order to then maybe start both the SGLT2 and the finerenone together.

Dr. Wanner:
Yeah. We saw in CONFIDENCE, a 7 mmHg blood pressure drop. And you are right. Maybe you can save another drug and enhance adherence and compliance.

I didn't point to my case, what I did. I mixed the amlodipine in a polypill. At least here in Germany, we have this triple-drug combinations, meanwhile, in one pill at the same cost. So this may be also very important for general practitioners to handle their patients.

Dr. Mottl:
Yes, I agree. We talk about patients not wanting to take too many medicines, but it's really they don't want to take too many pills. So I think having the polypill is really important, and I'm looking forward to maybe someday seeing a combination SGLT2 inhibitor along with finerenone.

Tell me a little bit about what brought you to add on the semaglutide for your patient.

Dr. Wanner:
This was the latest addition. It was only after the results of the FLOW trial, which came along exactly 1 year ago. So the semaglutide addition was the latest. And I'm a nephrologist. My colleague next door is a diabetologist. He is using it much more, but he has also the bigger packages of people, and so they use it for anti-obesity treatment. And now we have the kidney-protective effects. And I had, still, with this patient, 200 mg/g albumin, which is already much better, but I thought I can do even better. And I can tell you, I have now some patients where you can really stabilize the progression. And I'm following now the 4-pillar concept.

And the 4-pillar concept, if you are in a country where reimbursement is where you can afford, that's a fantastic thing. Now, with CONFIDENCE, where you can give SGLT2 inhibitor and finerenone at the same time, you don't lose time. Yeah? And I think this is now, meanwhile, my main criteria because these patients are progressing with the high albuminuria. And sometimes, you cannot see it when you do not multiple measurements of creatinine over prolonged period of time and then, all of a sudden, 10% kidney function is already gone before you turn around.

Dr. Mottl:
Exactly. It's funny, I actually just had a patient in clinic this past week who was on all 4 pillars, but his semaglutide was only at 0.5. And since the FLOW trial used the 1-mg dose, even though his A1c was well controlled, I still brought him up in order to maximize his therapy.

Dr. Wanner:
Can I make a final plea to you?When you think about this entire concept, then you come to a conclusion that time is nephron mass, and think of all these nephrons and glomeruli which are hyperfiltering. Even if you have a GFR of 60, that's single-nephron hyperfiltration.So time is nephron mass. Don't lose time and try to protect your patient. I practice this so often and it works and I'm very happy to have these interventions on hand.

Dr. Mottl:
All right. Well, that's a great place to wrap up. That's all we have for today. Thank you so much to the audience for joining us and thank you, Dr. Christoph Wanner, for joining in and sharing your case with us today, discussing the optimal therapy for patients with CKD and type 2 diabetes.

Dr. Wanner:
Thank you.

Announcer:
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