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Finerenone and SGLT2 Inhibitors in Non-Diabetic CKD: Insights From FIND-CKD

Announcer:
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Dr. Cherney:
Hello from ASN Kidney Week 2026 here in Denver, Colorado. My name is Dr. David Cherney. I'm a nephrologist at the University of Toronto, and today I'm reviewing data that were presented from a subanalysis of the FIND-CKD trial.

And we know that SGLT2 inhibitors, as a class, have been shown to reduce the risk of kidney and cardiovascular risk in patients with kidney disease, essentially regardless of etiology, including diabetes status. We also know that in patients with type 2 diabetes who have an SGLT2 inhibitor and finerenone, a nonsteroidal MRA, added simultaneously, that there are additional reductions in UACR albuminuria when these therapies are used together versus when they're used alone. However, the effect of combination of an SGLT2 inhibitor and finerenone together in nondiabetic CKD remains largely unstudied, and that was the goal of the analysis that was presented at the ASN around assessing the effect of finerenone in combination with SGLT2 inhibition in patients with nondiabetic CKD.

And so by way of overall data and the analysis, I think it's important to recognize that the baseline characteristics in patients who were on an SGLT2 inhibitor or not at baseline were very consistent, especially in terms of level of albuminuria, GFR, and other baseline characteristics.

In terms of the main analysis, overall in the FIND-CKD trial, there was a significant attenuation of loss of kidney function, so eGFR slope when finerenone was added, and that effect and benefit on preventing kidney function decline and slowing eGFR loss was consistent in patients who were taking an SGLT2 inhibitor at baseline and those who were not taking an SGLT2 inhibitor at baseline.

Similarly, not only was the total slope, so that's the slope from baseline until end of treatment, that was similar as I've mentioned. In addition to that, the acute effect on eGFR dipping, that's the acute hemodynamic effect that we see when we add finerenone and we add other classes of kidney-protective therapies. That dip was consistent in SGLT2 users versus nonusers, and the chronic slope was also consistent in SGLT2 users versus nonusers at baseline. And that effect, importantly, in terms of the primary endpoint, which was total slope, that effect was clinically and statistically significant in this analysis in the users and the nonusers.

What's so important as well is that the effect of finerenone was consistent in terms of the attenuation in reduction in cardiorenal risk in SGLT2 inhibitor users versus nonusers, and that was consistent across a variety of different composite endpoints. So the main composite endpoint in terms of cardiovascular kidney risks, so kidney failure, significant GFR decline, hospitalization for heart failure or cardiovascular death. And all the other composite endpoints that included the one that I've mentioned, but also the composite of kidney risk, the composite of kidney risk using a 40% decline in GFR, and the composite of hospitalization for heart failure or cardiovascular death also consistent in SGLT2 users versus nonusers.

From a safety perspective, there was nothing new that emerged in this analysis. As we know the effect and the risk of hyperkalemia is very low overall, and there were fewer numbers of events in both SGLT2 users and nonusers. Patients who take finerenone tend to

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have more hyperkalemia events, but as mentioned, those risks were very low across the board.

So, in summary, in this prespecified analysis of the FIND-CKD trial, finerenone reduced total eGFR decline, albuminuria, and the risk of cardiorenal composite endpoints consistently in patients with nondiabetic CKD in the SGLT2 users versus nonusers, and there were no new safety signals that emerged in this analysis from the FIND-CKD trial.

So that's the summary of the data. What's so important from a clinical translation perspective is that we now know much more about how to use these therapies in combination, SGLT2 inhibitors and finerenone, in patients with nondiabetic CKD. We have robust data with each individual class of drugs, so with SGLT2 inhibitors across trials such as the EMPA-KIDNEY trial and DAPA-CKD in terms of reducing cardiorenal risk. And we also have data with finerenone in patients with type 2 diabetes from the FIGARO and FIDELIO trials, and in patients with nondiabetic CKD from the FIND-CKD trial. We now know that when these medications are used in combination in nondiabetic CKD, that there is consistent benefit no matter how we define that in terms of the slope or in terms of composite endpoints and we know that these therapies can be used together safely.

So from the ASN Kidney Week 2026, I'm Dr. David Cherney. Thank you very much for listening and enjoy the rest of the meeting.

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