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

Personalized Treatment Strategies for Hyperkalemia: Bridging Evidence and Clinical Practice Needs

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Dr. Kelepouris:
This is CE on ReachMD, and I'm Dr. Ellie Kelepouris. Today, we will review best practices for individualized therapy for patients with hyperkalemia. And the question is, how can we select the right potassium binder for the right patient?

The CKD Care HK Registry was designed to identify barriers to guideline-directed medical therapy in patients with heart failure and chronic kidney disease.

What we learned from the CARE-HK registry, particularly in the advanced CKD patient cohort, which is one of the first registries to really have patients in it with a GFR less than 40 mL/min, is that the barrier to up-titrating RAASi blockers, which are renal protective and cardiovascular protective, was the fear of hyperkalemia. In fact, in the heart failure population, the RAASi blockers were either down-titrated or mitigation of hyperkalemia with SGLT2 use.

In the CKD cohort, we saw very poor adoption of GDMT in terms of RAAS blockade use, even though the patient's potassiums were in the normal range.

What did the registry teach us? It teaches us that physicians are loathe to up-titrate RAASi blockers for fear of hyperkalemia, with only a 60% adoption of RAASi blockade use in populations vulnerable for heart failure and also for progressive kidney disease.

So it's critically important that when we make decisions about pharmacotherapy as it relates to both renal protection and cardiovascular protection, both in patients with heart failure and with chronic kidney disease, that we use the right algorithms of care. And what medications you use are critically important.

We also have practice guidelines, which are guideline-directed medical therapy pointing to the use of RAAS blockers, RAAS blockade, both with ACEs and ARBs, to provide renal and cardiovascular protection in our patients with heart failure and chronic kidney disease, particularly as they advance to stages 3s and 4s. The barrier to optimizing guideline-directed medical therapy is the observation that patients on RAAS blockers, particularly with diabetes and advanced CKD, have episodes of hyperkalemia.

The feeling that hyperkalemia is an adverse event that may lead to other adverse events, such as arrhythmias, is really something that

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concerns physicians. And the knee-jerk reaction is to de-escalate doses of medications that really are preventing their kidneys from advancing, preventing their heart failure from being exacerbated. So hyperkalemia should not be a barrier to use of guideline-directed medical therapy. But we have methods to decrease the serum potassium while keeping the RAAS blocker on board for care of these patients.

There are 2 binders available: a binder whose counter ion is calcium and a binder whose counter ion is sodium. I think it's important to choose the right binder in the right clinical setting. And in fact, minimizing sodium load to patients who already have CHF exacerbation and edema may not be the right step to take.

So if you are going to continue RAS blockade and see an elevation in serum potassium in patients predisposed to edema and heart failure, such as those in the CARE-HK Registry, and stage 4 CKD, then thinking about providing a potassium binder that does not have a counter ion of sodium or providing sodium loading to those patients is really important.

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