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Episode 1 Part B: Diagnosis, Monitoring, and Risk Assessment

Announcer:

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Dr. Weber:

Hello, this is CME on ReachMD, and I'm Dr. Michael Weber at the Downstate University of the Health Sciences in New York.

Dr. Rossing:

And I'm Dr. Peter Rossing from Steno Diabetes in Copenhagen.

Dr. Weber:

I'd like to revisit a case that I think is particularly interesting because it's a common and serious issue that primary care physicians deal with a lot. And that is the patient who's overweight or obese, history of hypertension, history of type 2 diabetes, both being treated, lipid disorder, statin being used, all the right things, in a sense, being done, renal function reasonable but deteriorating somewhat. And then the appearance of albuminuria, at first microalbuminuria then perhaps somewhat more serious than that, not dramatically high numbers, but time for us to be concerned.

So, Peter, bearing that background in mind, what should we do to really get to the bottom of a patient like this and to make sure we're anticipating and identifying problems that this patient might be facing?

Dr. Rossing:

Well, thanks. I think this is, as you mentioned, a quite typical patient that we meet often. It's a patient where already a lot has been done, and actually, we're quite good at measuring kidney function. Almost everybody with diabetes has a regular measurement of kidney function or estimated GFR, but what is often lacking, but not in this person, is measurements of albuminuria. And albuminuria is super important because you can have high albuminuria even with normal kidney function, but at any level of GFR, you'll increase the risk for progression of kidney disease, but also for cardiovascular disease and also for mortality if also albuminuria is measured and elevated. So we need to think both GFR and albuminuria when we try to define a patient or make the diagnosis of such a person.

And for a person like this, it's important that we control glucose, we control blood pressure, we control lipids, but it's also important that we think that now there are new therapies that in addition to the traditional RAS blockade, which has been standard of care, if you have increased albuminuria, we have new opportunities. This is highlighted in, for instance, the KDIGO guidelines and also in the ADA guidelines and many other guidelines, that we have lifestyle, as for anybody with type 2 diabetes, as a foundation, so weight control, physical activity, healthy diet, but then we add metformin for glucose control. We add SGLT2 inhibitors, not for the glucose control or not only for glucose control because they don't work on glucose if you have impaired kidney function, but for protection of the kidney. As soon as there's increased albuminuria or decline in kidney function, we should consider SGLT2 inhibitors.

And we also have seen that nonsteroidal mineralocorticoid receptor antagonists like finerenone have shown, like the SGLT2 inhibitors,

reduction in progression of kidney disease and less cardiovascular events in this high risk populations. And also we have seen that GLP-1 receptor agonists provide benefit on glucose and on cardiovascular and kidney events. So we certainly, from many years of only a few opportunities like RAS blockade, ACE inhibitors, or ARBS, have several opportunities that we can implement. And currently it's being debated. Should we have like for heart failure, all these therapies in place, or should we take them one at a time and, for instance, titrate according to albuminuria reduction? This person we previously discussed had increase in RAS blockade and a reduction in albuminuria, but then an increase again. Maybe then adding these other agents until albuminuria is reduced is one way to go or simply add as many as we can get in order to control progression of kidney disease.

Dr. Weber:

Well, thank you, Peter. And that is important because a lot of us have found it frustrating, particularly the non-nephrologists, and knowing how best to manage albuminuria. And here in the United States, I suspect also in Europe, finding a nephrologist, making appointments for patients is not as easy as it should be. And so primary care people are expected to take much more of a personal role in managing this. I do recall, already a few years ago, there was some evidence that the use of spironolactone, the mineralocorticoid receptor antagonist, was helpful. That was the good news. The bad news, it's a difficult drug to use. Patients don't like it, and after a while, only a very small handful of patients actually do take it. So the availability, as you mentioned, of the nonsteroidal mineralocorticoid receptor antagonists, such as finerenone, has made a big improvement in our treatment selection allowing us to get those benefits without the side effects or at least with much more acceptable side effects.

I think you've summarized beautifully where we need to go with this because clearly getting albuminuria reduced has to be a very high priority, while at the same time we shouldn't just be kidney focused. And I am very grateful you've brought this out: We have to think about the heart because heart failure, coronary disease, peripheral arterial disease, if it comes to that, these are all lurking in the wings, so to speak, particularly in these sorts of obese patients with diabetes, hypertension, and so forth. And we have to be ready to anticipate them and treat them not when it's late, but try and introduce treatment right at the beginning. That's when we're going to get the best long-term results.

Peter, I really appreciate your comments. That's all the time we have for today. Thank you, everyone, for joining us.

Dr. Rossing:

Thank you.

Announcer:

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