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The Future Is Now: Integrating Novel Therapies in Hyperphosphatemia Management

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Episode 8

Dr. Sprague:
This is CME on ReachMD, and I'm Dr. Stuart Sprague from the University of Chicago Endeavor Healthcare. Here with me today is Dr. Steven Fishbane. Dr. Fishbane, how would you envision novel therapies like NHE3 inhibitors such as tenapanor, making their way into clinical practice and treatment regimens?

Dr. Fishbane:
Yeah, thanks for the question, Stuart. It's I think my experience, just as a clinician, we had been involved with the research with tenapanor and now in clinical practice, I feel like my knowledge in terms of how to use the drug and introducing it has evolved. So I started in peritoneal dialysis, where patients typically have a certain amount of constipation, and this drug may help a bit in that direction. And it was as add-on therapy. I'm cognizant that the indication for the drug is for patients that have had an inadequate response to phosphate binders, or patients that have been intolerant, and we certainly see that with phosphate binders. So I would be starting in PD with patients that were not achieving goals. And from there, moving to the hemodialysis in center realm, where there are just so many patients that we're taking care of and, frankly, frustrated by the fact that the patient is not getting to goals. They are taking the binders, and I think making a good-hearted attempt to take the binders.

And in those patients, we're looking for those who are above targets, who are on a binder and using tenapanor, for example, as an add-on therapy, and following closely to see what kind of effect that we've gotten. Have we gotten the efficacy that we've looked for? Have we moved towards the normal range for phosphorus? And there, we've had different experiences where it's classic add-on therapy and tenapanor is added to a classic binder, and the patient does very well.

But in addition, we've had patients where the traditional phosphate binder has dropped off as part of therapy where intolerance has been an issue, and now the therapy becomes more focused on the tenapanor and continuing to work towards targets. So I think there's different ways that the drug can be effectively introduced into therapy. And I think that's some of the frustration that we've had over time, and the ability to get towards goal with an agent, which maybe is a little bit easier to use for patients, gives us opportunities that just haven't been there before. So thank you for the question.

Dr. Sprague:
Yeah, no, Steven, it's a very appropriate answer. It's interesting because, again, I also, as were you, involved in the clinical studies, and found it very exciting. I initially did not focus on peritoneal dialysis patients, though we do have a sizeable PD practice, and with this whole issue of constipation and everything else, we then re-shifted that way and have really focused there.

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And the patients have really appreciated it, because in addition to getting their phosphate under control, they've stopped taking their laxatives and stool softeners. And my approach has been similar to how you said, is an add-on therapy and decreasing their phosphate binder dose. And I find most patients have found that very good.

The other area which I found very surprising, is we have some chronic nursing homes or extended care facilities that have dialysis units in them that we round at. And I don't know, for some reason, even though medications are passed out by the staff there and everything else, we've had a hard time getting phosphate control. And their adding this on has been remarkable. And matter of fact, the nurses the registered dietitians there have been very excited about it, because they've really been able to get phosphate under control on a regular basis with the patients in using that scenario.

Dr. Fishbane:
We have the same setup, and it's so interesting because I've had exactly that same positive experience, which has been really nice. I mean, look, no matter how we look at it, being able to move from a very long era where all we had were phosphate binders to now having a phosphate absorption inhibitor and being able to take advantage of two mechanisms, it's just been a really nice opportunity. Thank you.

Dr. Sprague:
Yeah, that it has. Well, thank you very much. I appreciate your insight and comments. I know this has been brief, but I hope we give everyone listening to this something to think about, and thank you all for tuning in.

Dr. Fishbane:
Thank you.

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