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The Link Between Albuminuria and CV Risk in Non-Diabetic Patients

Announcer:
You're listening to *Conversations in CV Risk Assessment* on ReachMD. Here's your host, Dr. Brian McDonough.

Dr. McDonough:
Welcome to ReachMD. I'm Dr. Brian McDonough, and joining me to discuss the role of albuminuria in cardiovascular risk screening for non-diabetic populations is Dr. Anu Lala. She's an Associate Professor of Medicine in Cardiology at the Icahn School of Medicine at Mount Sinai in New York. Dr. Lala, thanks for being here today.

Dr. Lala:
Thanks so much for having me.

Dr. McDonough:
So if we start with some context, Dr. Lala, why is it so important to understand the connection between albuminuria and cardiovascular risk, particularly in non-diabetic populations?

Dr. Lala:
Yeah, I'm so glad you asked this because this is such an important evolving need in our subspecialties where we're now seeing the importance of understanding this distinction, regardless of your subspecialty.

So albuminuria reflects early vascular injury. It also reflects endothelial injury or dysfunction. It is a reminder to us that when we have albuminuria and it represents that vascular injury or that endothelial dysfunction, these are the central pathophysiologic issues that drive cardiovascular disease. So essentially, albuminuria is this indicator earlier on. Now, large population studies have interestingly shown—consistently in fact—that even low levels of sustained albuminuria predict future cardiovascular events independent of diabetes. We used to think, "Okay, you have diabetes, you're going to have protein in your urine. We're going to check your urine albumin." Now we're seeing that across broad populations, regardless of diabetes status.

Dr. McDonough:
With that background in mind, let's take a look at some specific guideline recommendations. The 2025 ACC/AHA blood pressure guidelines advise clinicians to include urine albumin-to-creatinine ratio, or uACR, testing in the initial lab evaluation for all adults with hypertension, which is a big change from 2017 when it was optional. How do you interpret the shift in guidance? And what does it tell us about the developing role of albuminuria in cardiovascular medicine?

Dr. Lala:
Yeah, I'm so happy to see this because assessing biomarkers is one thing, but the recognition of how patients need to be treated more holistically—and I don't mean alternatively, I mean holistically—in that we recognize that all the systems are truly interconnected. The change in these guidelines reflects this recognition that albuminuria is a powerful—though it's conventionally a kidney biomarker—cardiovascular biomarker, and it's not just a kidney one.

When we see an elevated uACR, this signals that we as clinicians need to be treating our patients more proactively. We need to make sure that their glucose is adequately controlled. We need to make sure that their weight is in the optimal range. We need to make sure that their blood pressure is in the optimal range and that they're on the appropriate medications: SGLT2 inhibitors and renin-angiotensin-aldosterone system inhibitors. And so this is what we can do to proactively mitigate cardiovascular risk. And albuminuria is a tool to help us remind us to do so.

Dr. McDonough:
Building on that, the KDIGO 2022 consensus report highlights obesity, atherosclerotic cardiovascular disease, and metabolic syndrome as chronic kidney disease progression risks that warrant albuminuria monitoring. With these risks in mind, do you see screening as a more proactive tool for risk mitigation? Or a response to existing progression?

Dr. Lala:
Can I say all of the above? I mean, I think that it's all of the above, really. I think albuminuria can be an early indicator of cardio-kidney-metabolic health stress, so it can be a reminder to us to optimize those cardiometabolic risk factors.

I think monitoring it allows for us to see that the treatments that we've put into place are effective. So by mitigating albuminuria, is what we're doing enough? Have we gotten it down to a low range, less than 30 mg/g, for example? And then I would say that translates into responding to existing progression.

So if I see that despite implementing all the appropriate treatments that this patient's albuminuria continues to be elevated and sustained, then it really speaks to me as to how high risk this individual is. Is there anything else that I can optimize further? If not, I want to make sure that I'm in touch with my nephrology and cardiovascular colleagues so that we're all addressing this patient's risk as aggressively and as proactively as possible.

Dr. McDonough:
For those just tuning in, you're listening to ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Dr. Anu Lala about the connection between albuminuria and cardiovascular risk in non-diabetic patients.

So, Dr. Lala, if we continue our discussion on guideline recommendations, the ADA noted in their 2024 standards of care in diabetes practice guidelines that people with established chronic kidney disease should have their urinary albumin and eGFR monitored one to four times per year, depending on kidney disease stage. With that being said, what challenges might we face when implementing this kind of monitoring? And how can we overcome them?

Dr. Lala:
Yeah, you're getting to the practical side of things, right? First, we need to remember to do it, regardless of whether you're a nephrologist or not. Second, I think sometimes we see that there's limited access with respect to assessing it routinely in our laboratories. We also, importantly, once it's assessed, need the appropriate infrastructure to make sure that we're following up on those results. And that, like you said, we're doing it at multiple time points—four times a year, for example. So are we doing this consistently and monitoring it consistently? And that requires clinician awareness. It requires infrastructure for follow-up, and it requires routine access to being able to test for it.

I would also say that we're—in our clinic, for example—very used to doing blood tests, but then to tell the patient that they need to use the restroom and give us a urine sample, it is a different workflow. So I think we need to accommodate accordingly. How far is the restroom from your clinic, et cetera. So I think there are some potential hurdles, but not those that are not easily surmountable.

Dr. McDonough:
Taking a bird's eye view now, what practical steps can we take to start integrating albuminuria testing into routine risk assessment? And what impacts might it have on patient management?

Dr. Lala:
Yeah, I think—and I'm sharing how I have changed my own practice—this needs to be a part of our routine lab draw. Just the way I'm looking for pro-BNP in my patients living with heart failure, just the way I'm assessing for hemoglobin on a relatively routine basis, just the way I'm certainly looking at creatinine as a heart failure clinician, I need to be looking for uACR on a routine basis.

And I think that—now, this is where we go not from being reactive, but rather proactive—earlier uACR assessments can really potentially lead to more timely adjustments and optimization of treatment for our patients.

Dr. McDonough:
As we come to the end of our discussion, Dr. Lala, do you have any key takeaways that you'd like to share with our audience?

Dr. Lala:
I would say the fact that we are learning the importance and the value of the fact that all of our organ systems are interconnected. I think the more we recognize and appreciate that, the better clinicians we will be. Oftentimes, we as cardiologists will say, "Nope, this is our lane, right here. This is what I take care of as a cardiologist, just this part of the chest." But albuminuria and its assessment and the risk that it confers is a reminder of how interconnected these systems are and how we need to address patients as whole bodies, rather than

just subspecialty organ systems.

Dr. McDonough:
With those final comments in mind, I want to thank my guest, Dr. Anu Lala, for joining me to discuss how we can use albuminuria to detect cardiovascular risk in non-diabetic patients. Dr. Lala, it was great having you on the program.

Dr. Lala:
Thanks so much. I loved our conversation.

Announcer:
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