Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/clinical-practice/diabetes-and-endocrinology/real-world-evidence-effectiveness-of-finerenone-in-reducing-uacr-in-patients-with-ckd-and-type-2-diabetes/70663/

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Real-World Evidence: Effectiveness of Finerenone in Reducing UACR in Patients With CKD and Type 2 Diabetes

Announcer:
You're listening to GLC on ReachMD. This Data Pulse, titled "EASD 2026 Data Pulse: Finerenone Evidence Across the CKD Spectrum" is provided by GLC

Dr. Kovesdy:
Hello, I'm Dr. Csaba Kovesdy. I'm a nephrologist coming to EASD virtually from the University of Tennessee Health Science Center in Memphis, Tennessee.

Today, I'd like to share with you findings from a new real-world analysis examining the effectiveness of finerenone in reducing albuminuria in patients with chronic kidney disease and type 2 diabetes mellitus. We already know from randomized controlled trials that finerenone effectively reduces cardiac and kidney endpoint in patients with type 2 diabetes and chronic kidney disease. However, an important question remains: Do we see similar benefits in routine clinical practice, where patients often have different clinical characteristics and receive different medications?

To address this question, we conducted an observational study using the FOUNTAIN platform, drawing on data from US administrative claims, electronic health records, and laboratory measurements. We identified 6,206 patients initiating finerenone, and we compared them with approximately 25,000 propensity score-matched controls. Cohort participants had an average age of 66 years, and their median estimated GFR was 53 mL/min. Importantly, this was a population receiving contemporary guideline-directed medications: approximately 86% were on a RAAS inhibitor, 63% were on an SGLT2 inhibitor, and 36% were receiving GLP-1 receptor agonists.

The outcome of interest was the likelihood of lowering albuminuria by a prespecified threshold of 30%, 50%, or 70%. The results were remarkably consistent across all 3 of these thresholds. Compared to matched nonusers, patients initiating finerenone had an 82% higher likelihood of a 30% reduction in UACR, an 86% higher likelihood of a 50% reduction, and a 97% higher likelihood of a 70% reduction in UACR. Furthermore, longitudinal analysis showed that albuminuria declined rapidly after finerenone initiation and was consistently present during a follow-up of up to 15 months.

What do these findings mean for clinicians? Well, first of all, these findings confirm the importance of albuminuria as a readily available and important risk disease marker. This is present even in patients receiving up to triple combinations of guideline-directed medical therapies, indicating that further expansion of therapy in these patients can be useful. Second, our findings confirm results from clinical trials that finerenone can effectively reduce albuminuria and improve renal outcomes, even in a population that is unselected in patients similar to your own patients in clinical practice.

To summarize, the key takeaway is that finerenone initiation was associated with substantial and sustained reduction in albuminuria in routine clinical practice, even in a population frequently receiving other kidney protective therapies.

Thank you for your attention.

Announcer:

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