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Implementing Potassium Binders: Practical Dosing and Long-Term Follow Up

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Dr. Burton:
Hi, everyone. This is CME on ReachMD. I'm Dr. James Burton, and it's an absolute pleasure to be joined by Dr. Ellie Kelepouris. Hi, Ellie, nice to see you.

Dr. Kelepouris:
Hi, Jim. Good to see you too.

Dr. Burton:
And I think we're going to start this one off with a reflection on a case that you've seen in this kind of arena that you're going to share through, and we're going to talk through together.

Dr. Kelepouris:
I think that guidelines are written really to care for patients. And so really focusing on a real life patient case. And this is my patient. I think it would really be important to talk through when you initiate and titrate and long-term follow up of patients with chronic kidney disease and other medications, particularly RAASi blockers and potassium binders.

And one case that I'm going to present is a patient with type 2 diabetes mellitus, chronic kidney disease stage 3A. So she does not have significant albuminuria. This patient, though, has hypertension above goal range. She also does not really follow a low sodium diet, a low potassium diet, and frequently she really has high blood pressure at home. And in general, over the last 2 years that I followed her, her creatinine has increased, her GFR has dropped, and she has had microalbuminuria with a uACR greater than 300 mg/g.

Now, our guidelines in kidney disease, CKD KDIGO guidelines tell us that RAAS blockade use and MRA, first-line therapy for patients with chronic kidney disease with albuminuria with or without diabetes. And so this patient really has been on ACE therapy and developed a cough, and I switched her to an ARB therapy. And what I noticed was that within 4 to 5 weeks after I saw her, she had been seen by one of her primary care doctors, and that person stopped the ARB medication.

So I think it's really important that we communicate with the colleagues who help us in the care of our patients and we have some guidelines that we'd like to share with them. And that is that ACE and ARB therapy really should not be discontinued unless the serum creatinine rises by more than 30% within 4 weeks following initiation of treatment or an increase in dose.

It's also important to note that this rise in creatinine really is a hemodynamic protective effect across the glomerulus. That really, that's what these agents were developed in a petri dish, really to reduce glomerular pressure and therefore decrease progression of kidney disease and reduce albuminuria.

So that's an important clinical consideration and an important teaching message that we should work with our colleagues in the cardiology space, in the primary care space, with endocrinologists in a collaborative way, so that we are all on the same page.

If, in fact, your creatinine does go up, rather than stopping the RAAS entirely, addition of potassium binders are really important here. Also consider reducing the dose in the setting of symptomatic hypotension or uncontrolled hyperkalemia despite medical treatment. And therefore, although people think that potassium is elevated in advanced CKD stages in patients with or without diabetes, that, in fact, is not correct. We see hyperkalemia at all stages of chronic kidney disease. So therefore, the continuation of guideline-directed medical therapy, including RAAS blockers and mineralocorticoid antagonists, really should be continued throughout the continuum of chronic kidney disease.

We do recommend that we closely monitor serum electrolytes and signs and symptoms of fluid overload in patients sensitive to sodium intake, such as those with heart failure and CKD. And diuretics do play an important role here.

Additionally, the use of SGLT2 inhibitors in this space is not only first-line therapy for patients with heart failure, but also are being used in patients with chronic kidney disease to mitigate the effects of sodium retention and hyperkalemia in patients. So the two partners in this space, both the SGLT2 inhibitors and ACE inhibitors, are really critically important.

So those are the three pillars of care that I think we really need to be familiar with.

Do you have any thoughts about how you would approach this patient?

Dr. Burton:
You mentioned this is someone living with type 2 diabetes. We know that CKD is really common in that group. Probably 40% of people with type 2 diabetes are going to have some kind of kidney impairment. You mentioned they may or may not have albuminuria, but that is likely to progress. It's really key that we keep an eye out.

RAASi therapies are one of our pillars of management, as are SGLT2 inhibitors, and we need to remember that KDIGO tells us most people with CKD should be on an SGLT2 inhibitor—might actually mitigate acute kidney injury and hyperkalemia to a degree.

But it is absolutely right that these people in those situations need to be on goal-directed medical therapy, on the pillars of therapy, and keeping them on the right doses is absolutely key, because down-titrating is only going to have negative consequences.

Ellie, thank you so much. I think we've covered a lot there. Thanks to the listeners for joining in.

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