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Episode 2 Part A: The "High Risk" Patient: What Providers Need to Know

Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Weber:

Patients with chronic kidney disease who are considered high risk, but do not receive appropriate specialized treatment, represent a missed opportunity for the delivery of interventions to reduce the progression of their kidney disease and other complications. So let's explore how to identify high-risk patients so we may implement the right interventions to avoid long-term cardiovascular-associated consequences.

This is CME on ReachMD, and I'm Dr. Michael Weber, and I'm delighted to be working with Dr. Luiza Caramori. Luiza?

Dr. Caramori:

Nice to meet you. I'm Louisa Caramori. Great to be here and have this wonderful audience with us today.

Dr. Weber:

We're going to be talking about, in many respects, a patient typical of people seeing a primary care physician. She is a 64-year-old woman, on the borderline of being obese. So BMIs are in the 30 range. She's had hypertension for 20 years, done reasonably well with treatment. She's getting an angiotensin receptor blocker plus calcium channel blocker, reasonably well controlled. Her blood pressure most recently, 136 over 78. She's had type 2 diabetes, though, for 9 years and currently treated with metformin extended release 1500 mg a day. And her hemoglobin A1c has been varying between 6.4 and 7. She also needs rosuvastatin, which has reduced her LDL down to 68. The HDL is a little lowish, and her triglycerides a little on the high side. Her renal function shows an eGFR in the low 60s, which is the way it's been for the past few years. We did an echo and it showed left ventricular hypertrophy and left atrial enlargement, an ejection fraction of 64.

The issue of chronic kidney disease, though, became a little more urgent about a year ago when for the first time we found that she had microalbuminuria. We took another look 3 months later, and it had got worse. It was now about 195 mg/g, the album and creatinine ratio. It got even worse 3 months later. And we responded then by increasing her dose of valsartan from 80 to 320 mg a day. And it seemed to help because the albuminuria came back down again to about 122. Unfortunately, most recently, it went back up again to 335. So now we're at a position where we have to do something new. And clearly, we are in need of help from a nephrologist. Her creatinine, her serum creatinine has remained at around 1 g/dL, and her eGFR is a tiny bit low. Her potassium's 4.4.

She has no real history of cardiovascular disease or symptoms, though she has complained a little bit of limited exercise tolerance. So we do plan to do a stress test, probably a pharmacologic stress test since seeing as she's not that agile, not really enough to do a typical stress test. And we'll probably also take a look at her pro-BNP to see if there could be some heart failure lurking there.

So, Louisa, my question to you is, what's going on? What should the next steps be, and how is this patient best managed?

Dr. Caramori:

So it's a patient with type 2 diabetes, overweight to obese as over 30% to 40% of our population in general is, and probably 70% to 80% of the patients with type 2 diabetes who also has hypertension for long duration. And I'm glad to see that the ARB dose was increased in this patient. Because the goal is really to use the maximum tolerated dose, and that's what she probably is now with a goal of having a blood pressure of 130/80 or lower, when these patients have diabetes. and I agree with you, her glycemia control seems to be excellent, you know, A1c lower than seven, assuming there is no anemia, nothing else. This is really a great control.

But we can do better, I think, in terms of reducing her cardiovascular risk. As you know, patients, who have diabetes often die from a cardiovascular cause. So that's even more common as a cause of death than progressing to end-stage renal disease and dying from kidney failure. So it's really important to address that. So the patient is on an angiotensin receptor blocker. She's on a statin. Her glycemic control is excellent, but she remains albuminuric. So we needed to address that. And I think that we are in great time now where we have options. For 30 years we didn't have other options than ACE and ARBs. Now we do have options, and this patient could certainly benefit from drugs that would lower her albuminuria. Because her creatinine is out, and her GFR is low, and she has albuminuria with a very good A1c, I would probably target that albuminuria with drugs that not necessarily touch her glycemia control.

So I think that I would favor using a nonsteroidal MRA for her. On the other hand, with her GFR getting lower to the 60s, she probably has an indication for a SGLT2 inhibitor there. So I think that it's really important that we add on this. And I saw that this patient was checked again every 3 months, so that's fantastic, right? So you're looking at the impact of the therapy, what needs to be done, and we really needed to fight the inertia there.

Dr. Weber:

Well, thank you. There was some discussion about the use of mineralocorticoid receptor antagonists [MRAs]. And of course we have had available spironolactone. My experience with it has been, maybe because I don't dose it properly, maybe I've got patients who are too finicky, I don't get very good adherence to the treatment with spironolactone. But there are some new agents available now, so-called nonsteroidal MRAs, that they do seem to look promising for patients like this.

Dr. Caramori:

Yeah, I would agree. I think that this patient could be a good candidate for a nonsteroidal MRA. As you mentioned, spironolactone, especially if you go up on the dose, it's very difficult to tolerate. But perhaps more important than that, we don't have trials showing that these drugs come for additional protection for patients with type 2 diabetes and CKD, while with the newer nonsteroidal mineralocorticoid receptor antagonist, we do have this data. So certainly the drug of choice here would go towards these newer agents.

The only exception for now, until things might change with new data, is if these patients had more severe heart failure and a clear indication for spironolactone, for example. And you are the expert on that. So I will let you to extrapolate on that. So that, of course, you cannot use both agents. But other than that, I think that this lady would be a great candidate from nonsteroidal MRA.

Dr. Weber:

Well, thank you. That's a very good comment. And it's interesting actually that one of the new nonsteroidal MRAs has been included now in a study that is looking at heart failure as an endpoint. And hopefully we will get data on that fairly soon. But I really appreciate your comments very much, and I'd like to thank all of you who've been watching our discussion today for joining us.

Dr. Caramori:

My pleasure.

Announcer:

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