SID Società Italiana di Diabetologia

ASSOCIAZIONE MEDICI DIABETOLOGI

DIABETE OGGI

prevenzione e cura al centro del cambiamento

Nuove opzioni terapeutiche nella malattia renale diabetica

Martina Vitale

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Latina, 7 giugno 2025

La dott.ssa Martina Vitale dichiara di NON aver ricevuto negli ultimi due anni compensi o finanziamenti da Aziende Farmaceutiche e/o Diagnostiche

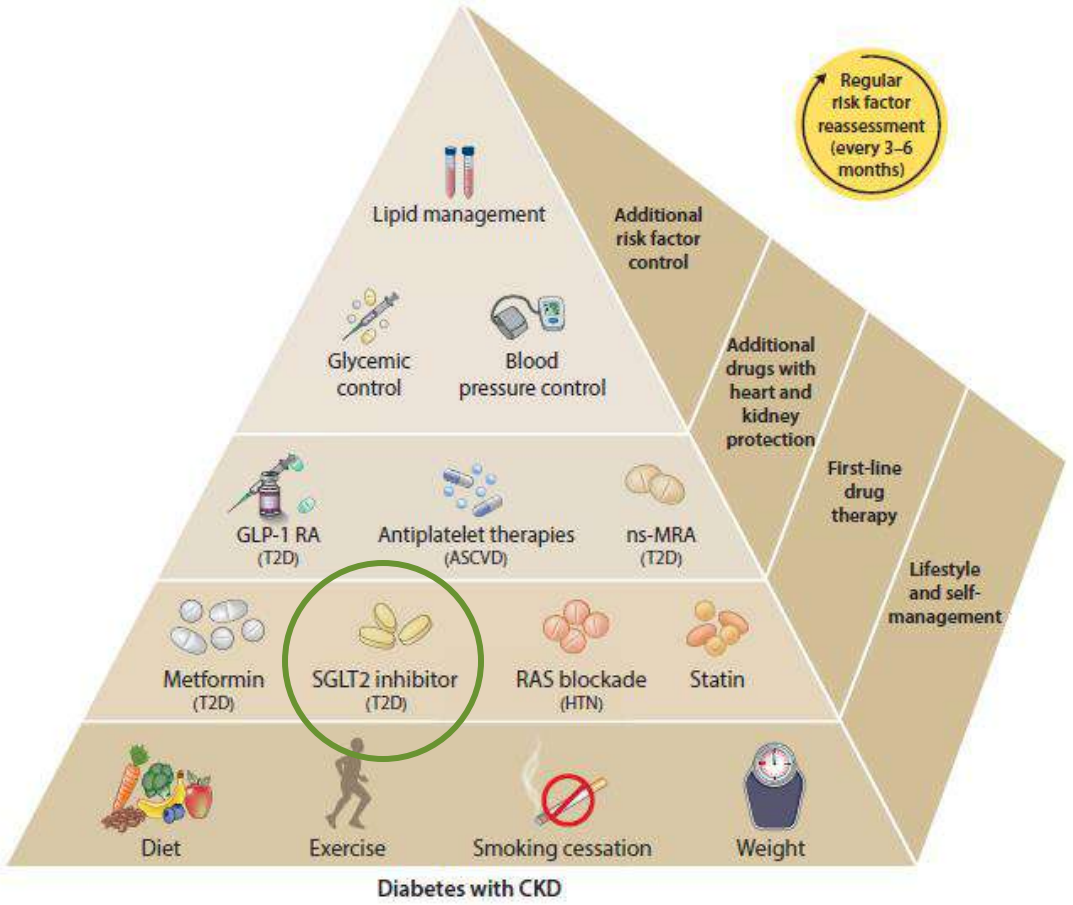
Dichiara altresì il proprio impegno ad astenersi, nell'ambito dell'evento, dal nominare, in qualsivoglia modo o forma, aziende farmaceutiche e/o denominazione commerciale e di non fare pubblicità di qualsiasi tipo relativamente a specifici prodotti di interesse sanitario (farmaci, strumenti, dispositivi medico-chirurgici, ecc.).

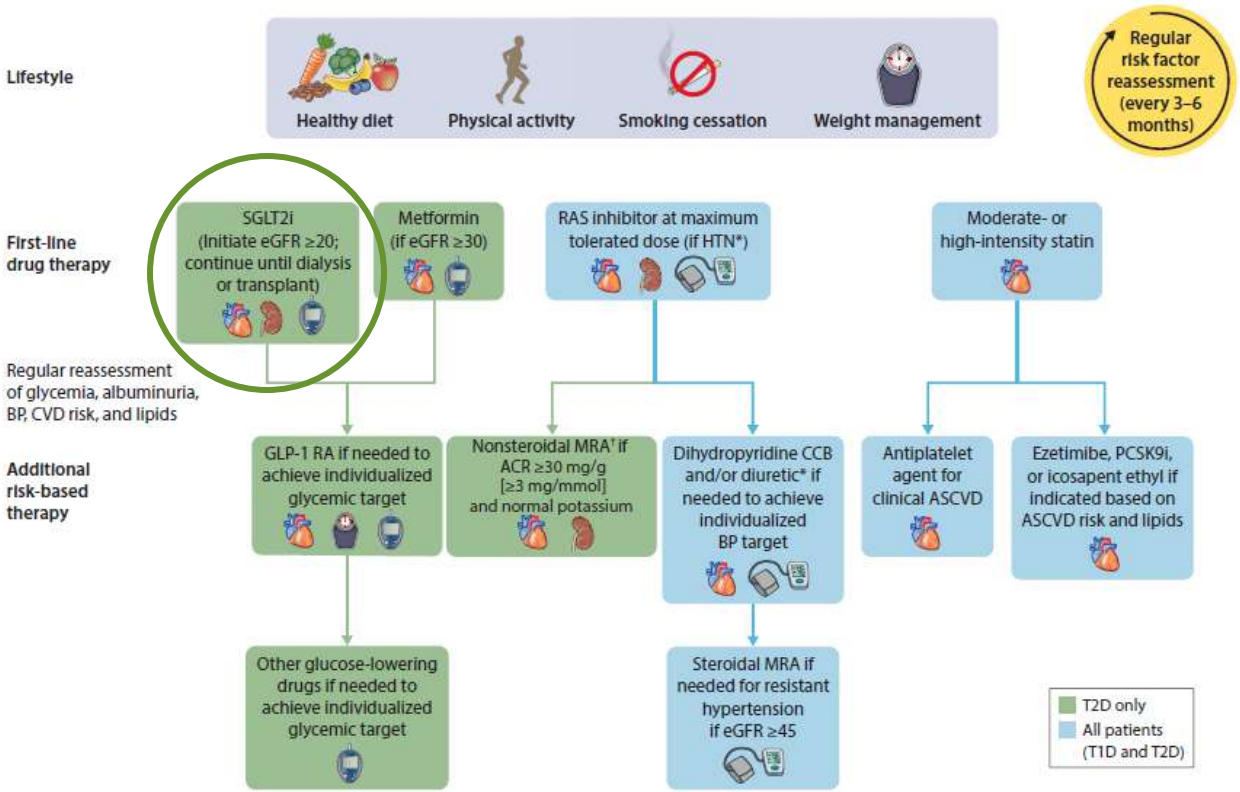
AGENDA

1. ”vecchie” molecole, vecchie e **nuove** evidenze – *SGLT2-i*
2. ”vecchie” molecole, **nuove** evidenze – *GLP1-RA*
3. **nuove** molecole - *Finerenone*

KDIGO 2022

CLINICAL PRACTICE GUIDELINE FOR DIABETES MANAGEMENT IN CHRONIC KIDNEY DISEASE





KDIGO Diabetes Work Group. Kidney Int. 2022 Nov;102(5S):S1-S127.

CKD TRIALS WITH SGLT2-i

CREDENCE (*canagliflozin*)
DAPA-CKD (*dapagliflozin*)
EMPA-KIDNEY (*empagliflozin*)

Inclusion Criteria:
- With or w/o T2DM
- ↓eGFR and ↑ UACR or ↓eGFR

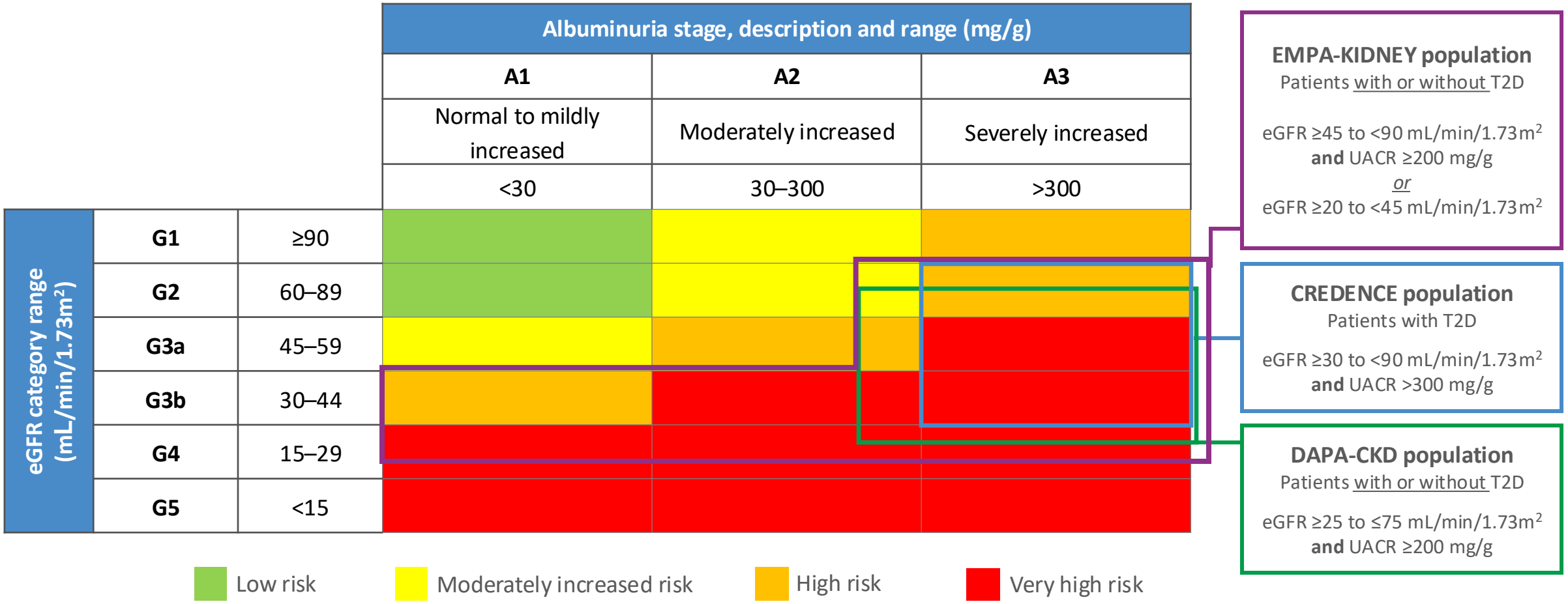
Primary outcome: renal composite

CKD TRIALS WITH SGLT2-i

Trial	CREDENCE	DAPA-CKD	EMPA-KIDNEY
Drug	Canagliflozin	Dapagliflozin	Empagliflozin
Participants, n (active drug/placebo)	4,401 (2,202/2,199)	4,304 (2,152/2,152)	6,609 (3,304/3,305)
Median follow-up, years	2.6	2.4	2.0
T2DM	100%	67.5%	46.0%
eGFR (ml/min/1.73m^2) (active drug/placebo)	56.3/56.0	43.2/43.0	37.4/37.3
Renal function at baseline			
Normal (eGFR ≥90)	4.8%	-	-
Mild impairment (eGFR 60-89)	35.4%	10.5%	21.2% (>45)
Moderate impairment (eGFR 30-59)	55.9%	75.0%	44.3% (30-45)
Severe impairment (eGFR<30)	3.9%	14.5%	34.5%
Albuminuria at baseline			
Normoalbuminuria	0.7%	-	20.1%
Microalbuminuria	11.3%	10.3%	28.2%
Macroalbuminuria	88.0%	89.7 %	51.7%

Perkovic V et al. N Engl J Med 2019;380:2295-306.; Heerspink HJL et al. N Engl J Med. 2020 Oct 8;383(15):1436-1446.; Herrington WG et al. N Engl J Med. 2023 Jan 12;388(2):117-127.

CKD TRIALS WITH SGLT2-i

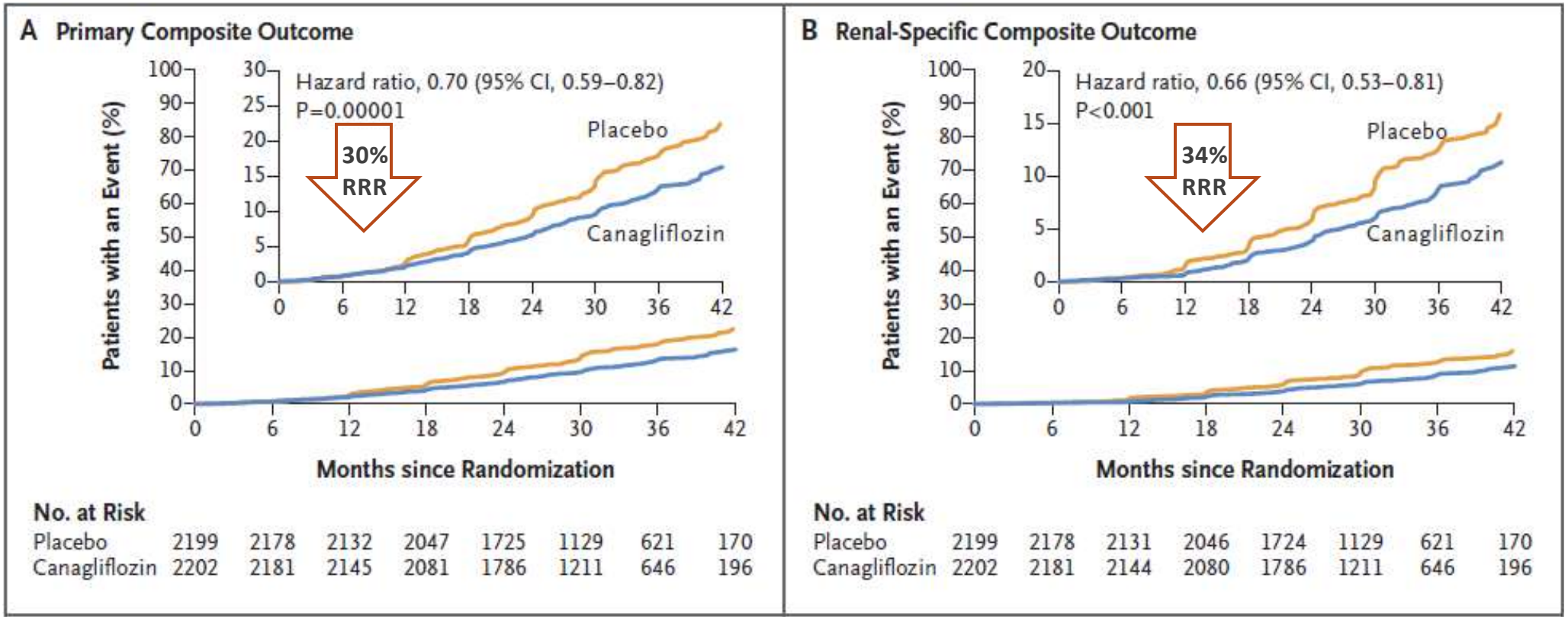


Perkovic V et al. N Engl J Med 2019;380:2295-306.; Heerspink HJL et al. N Engl J Med. 2020 Oct 8;383(15):1436-1446.; Herrington WG et al. N Engl J Med. 2023 Jan 12;388(2):117-127.

CKD TRIALS WITH SGLT2-i

Canagliflozin and Renal Outcomes in Type 2 Diabetes and Nephropathy

CREDENCE



Doubling of serum creatinine level, ESRD, or death from renal or cardiovascular causes

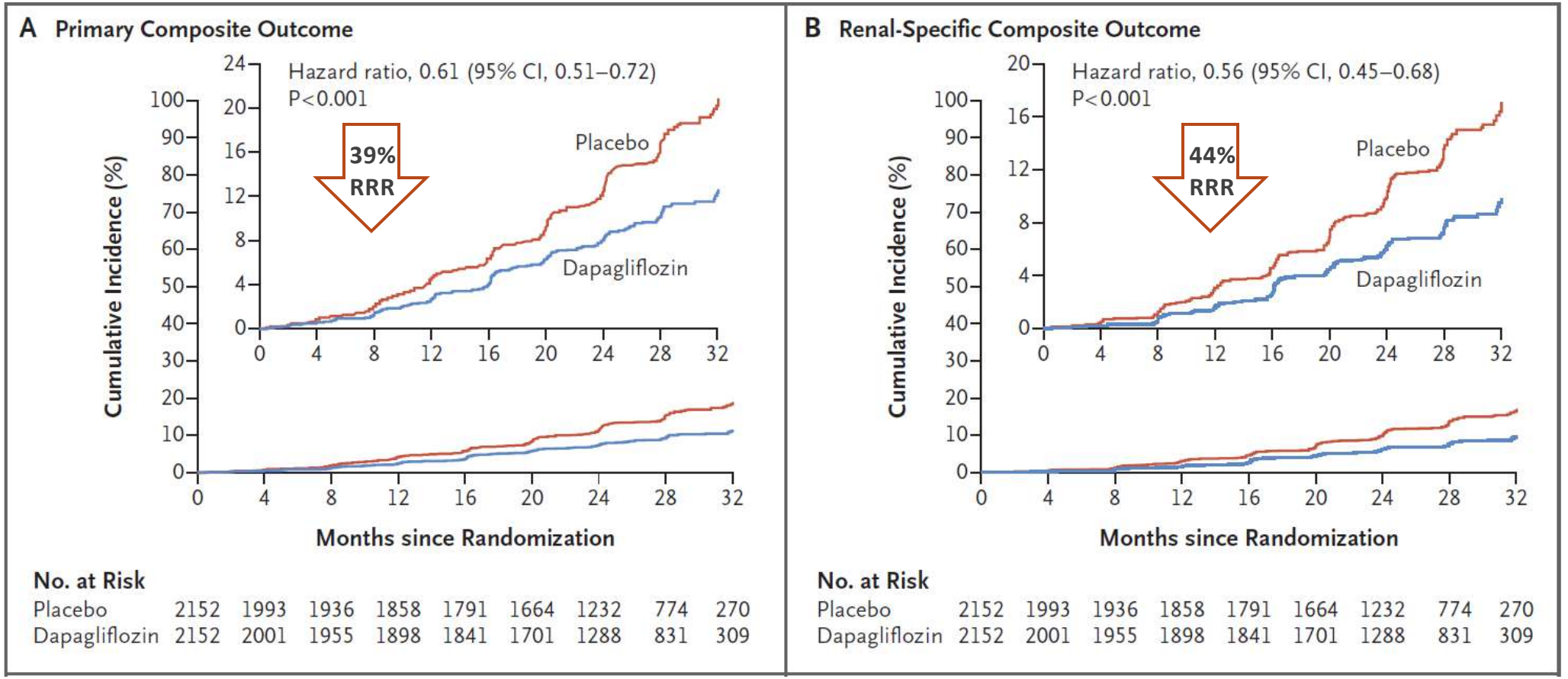
Doubling of serum creatinine level, ESRD, or renal death

Perkovic V et al. N Engl J Med 2019;380:2295-306.

CKD TRIALS WITH SGLT2-i

Dapagliflozin in Patients with Chronic Kidney Disease

DAPACKD



Sustained decline in eGFR ≥50%, ESRD, or death from renal or cardiovascular causes

Sustained decline in eGFR ≥50%, ESRD, or death from renal causes

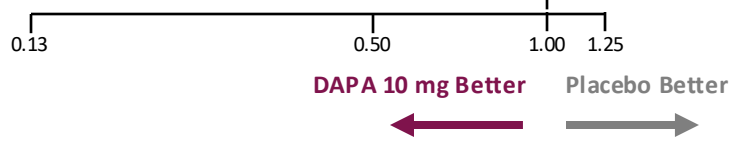
Heerspink HJL et al. N Engl J Med. 2020 Oct 8;383(15):1436-1446.

CKD TRIALS WITH SGLT2-i

Dapagliflozin in Patients with Chronic Kidney Disease

DAPACKD

	Number of Events				
	DAPA 10 mg (N=2152)	Placebo (N=2152)	HR	95% CI	p-value Interaction
Composite of ≥50% eGFR Decline, ESKD, or Renal or CV Death					
All Patients	197	312	0.61	(0.51, 0.72)	
T2D at Baseline					0.24
Yes	152	229	0.64	(0.52, 0.79)	
No	45	83	0.50	(0.35, 0.72)	
UACR (mg/g) at Baseline					0.52
≤1000	44	84	0.54	(0.37, 0.77)	
>1000	153	228	0.62	(0.50, 0.76)	
eGFR (mL/min/1.73m^2) at Baseline					0.22
<45	152	217	0.63	(0.51, 0.78)	
≥45	45	95	0.49	(0.34, 0.69)	

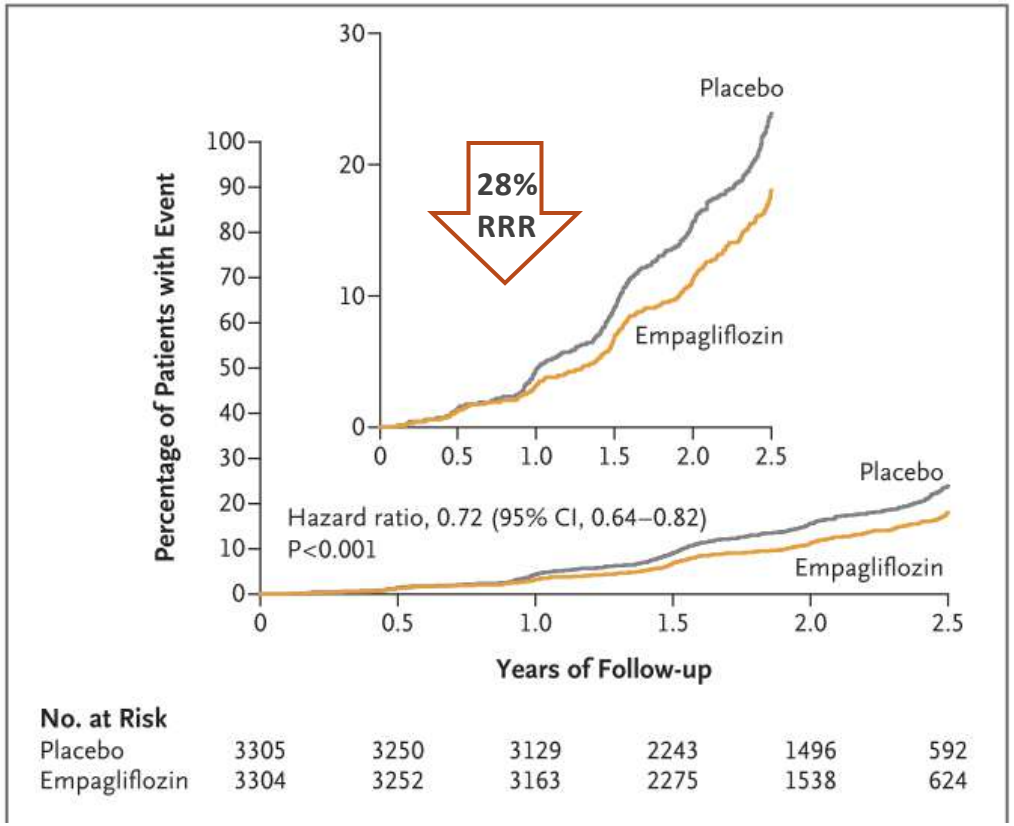


Heerspink HJL et al. N Engl J Med. 2020 Oct 8;383(15):1436-1446.

CKD TRIALS WITH SGLT2-i

Empagliflozin in Patients with Chronic Kidney Disease

EMPA-KIDNEY
The study of heart and kidney protection with empagliflozin



Sustained decline in eGFR ≥40%, ESRD, or death from renal or cardiovascular causes

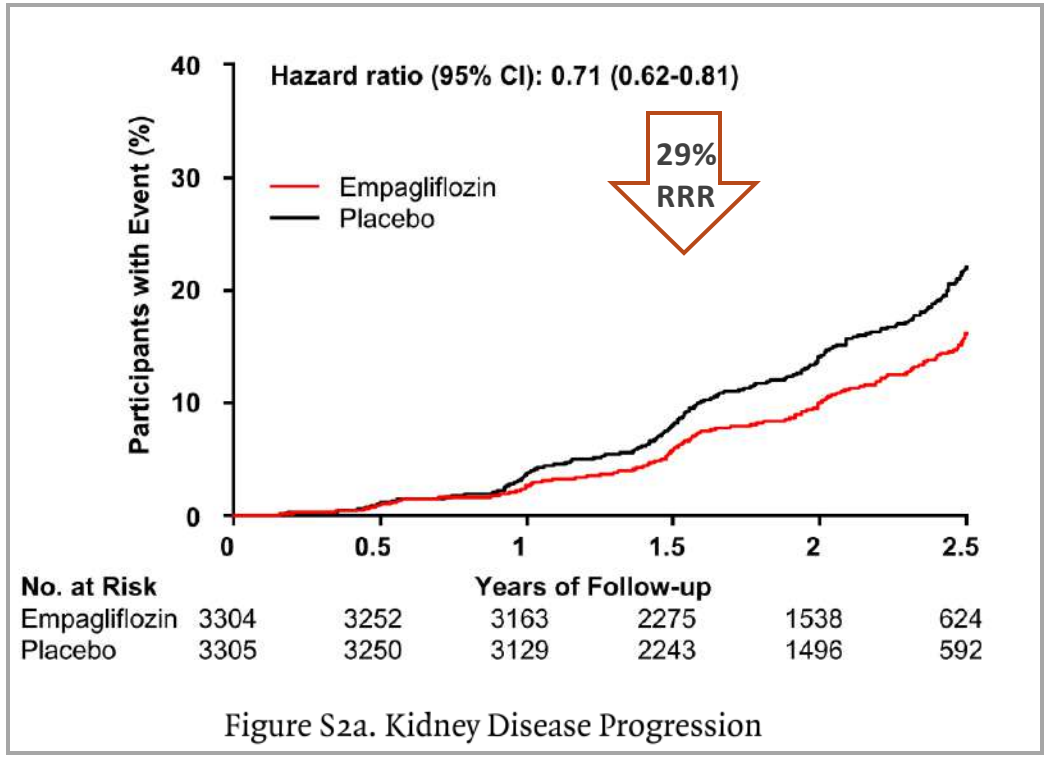


Figure S2a. Kidney Disease Progression

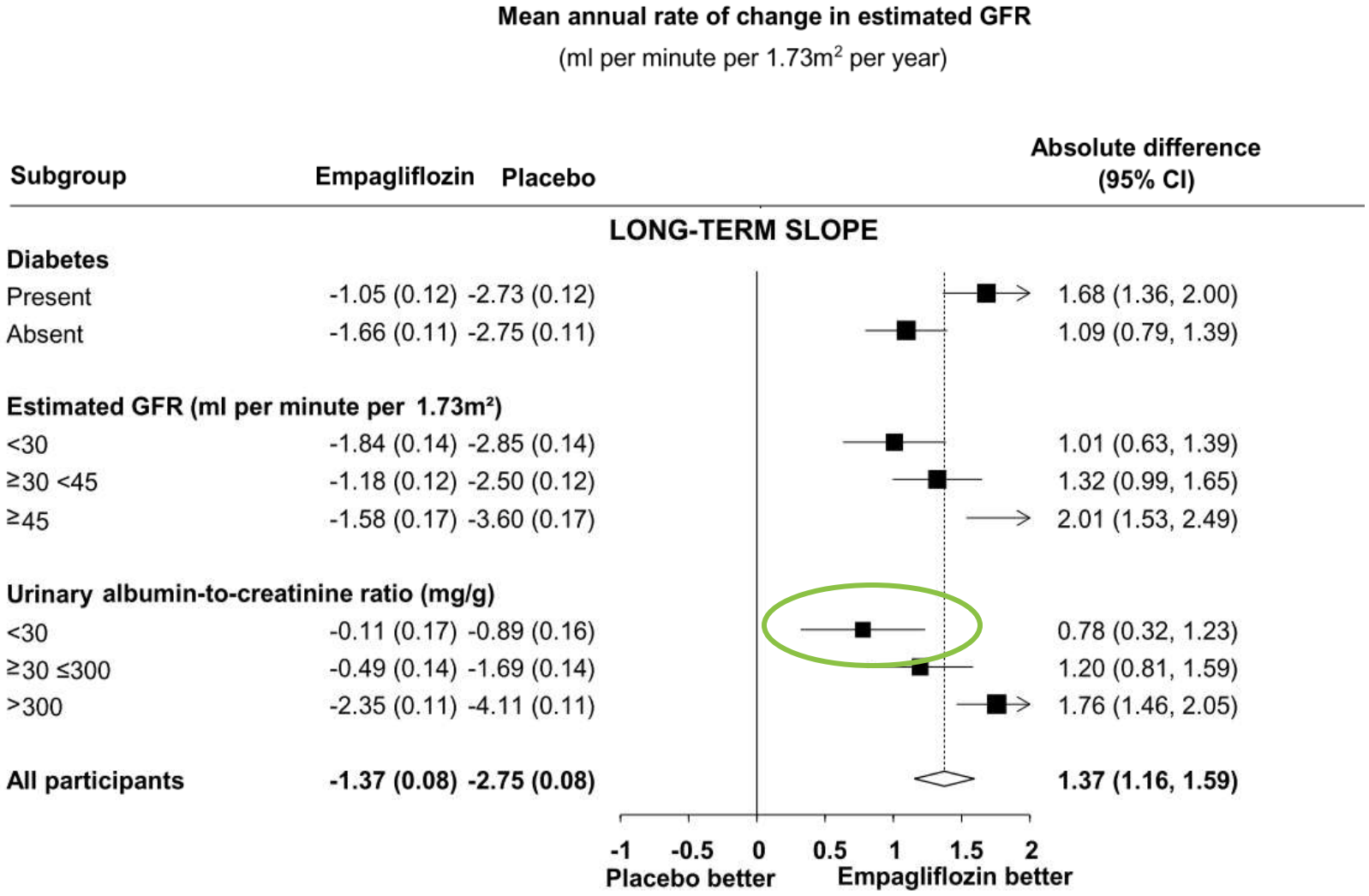
Sustained decline in eGFR ≥40%, ESRD, or death from renal causes

Herrington WG et al. N Engl J Med. 2023 Jan 12;388(2):117-127.

CKD TRIALS WITH SGLT2-i

Empagliflozin in Patients with Chronic Kidney Disease

EMPA-KIDNEY
The study of heart and kidney protection with empagliflozin



Herrington WG et al. N Engl J Med. 2023 Jan 12;388(2):117-127.

CKD TRIALS WITH SGLT2-i

Key outcomes of SGLT2-I trials

	CREDENCE (n=4401)	DAPACKD (n=4304)	EMPA-KIDNEY (n=6609)
Primary Composite Outcome (Progression of kidney disease or CV death)	HR 0.70 (95% CI, 0.59-0.82)	HR 0.61 (95% CI, 0.51-0.72)	HR 0.72 (95% CI, 0.64-0.82)
Progression of kidney disease	HR 0.66 (95% CI, 0.53-0.81)	HR 0.56 (95% CI, 0.45-0.68)	HR 0.71 (95% CI, 0.62-0.81)
Composite of CV death or HHF	HR 0.69 (95% CI, 0.57-0.83)	HR 0.71 (95% CI, 0.55-0.92)	HR 0.84 (95% CI, 0.67-1.07)
Hospitalization for any cause	-	-	HR 0.86 (95% CI, 0.78-0.95)
Death for any cause	HR 0.83 (95% CI, 0.68-1.02)	HR 0.69 (95% CI, 0.53-0.88)	HR 0.87 (95% CI, 0.70-1.08)
ESKD or CV death	HR 0.73 (95% CI, 0.61-0.87)	-	HR 0.73 (95% CI, 0.59-0.89)
ESKD	HR 0.68 (95% CI, 0.54-0.86)	HR 0.64 (95% CI, 0.50-0.82)	-
CV death	HR 0.78 (95% CI, 0.61-1.00)	HR 0.81 (95% CI, 0.58-1.12)	HR 0.84 (95% CI, 0.60-1.19)

Perkovic V et al. N Engl J Med 2019;380:2295-306.; Heerspink HJL et al. N Engl J Med. 2020 Oct 8;383(15):1436-1446.;
Herrington WG et al. N Engl J Med. 2023 Jan 12;388(2):117-127.

CKD TRIALS WITH SGLT2-i

Articles

Long-term benefits of dapagliflozin on renal outcomes of type 2 diabetes under routine care: a comparative effectiveness study on propensity score matched cohorts at low renal risk

Gian Paolo Fadini,[a,b,f,*] Enrico Longato,[c,f] Mario Luca Morieri,[a] Stefano Del Prato,[d] Angelo Avogaro,[a] and Anna Solini,[e]
DARWIN-Renal Study Investigators

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Fadini GP et al. Lancet Reg Health Eur. 2024 Feb 1:38:100847.

CKD TRIALS WITH SGLT2-i

Long-term benefits of **Dapagliflozin** on renal outcomes of type 2 diabetes under routine care: a comparative effectiveness study on propensity score matched cohorts at low renal risk

DARWIN-Renal

Obiettivo

Dimostrare l'efficacia a lungo termine di dapagliflozin su esiti renali multipli e sull'albuminuria nei pazienti con diabete di tipo 2 e basso rischio renale

Studio multicentrico **retrospettivo** comparativo di efficacia, condotto dalla **Società Italiana di Diabetologia** in 50 centri specializzati nella cura del diabete in Italia

Dal **gennaio 2015** al **settembre 2022**, i dati clinici sono stati estratti dalle cartelle cliniche elettroniche

- Pazienti avviati a **dapagliflozin**
- Pazienti avviati a **qualsiasi altro farmaco ipoglicemizzante**

I farmaci di confronto comprendevano:
DPP-4i (40%), GLP-1RA (22.3%), sulfoniluree/glinidi (16.1%), pioglitazone (8%), metformina (5.8%), acarbosio (4%)

Fadini GP et al. Lancet Reg Health Eur. 2024 Feb 1:38:100847.

CKD TRIALS WITH SGLT2-i

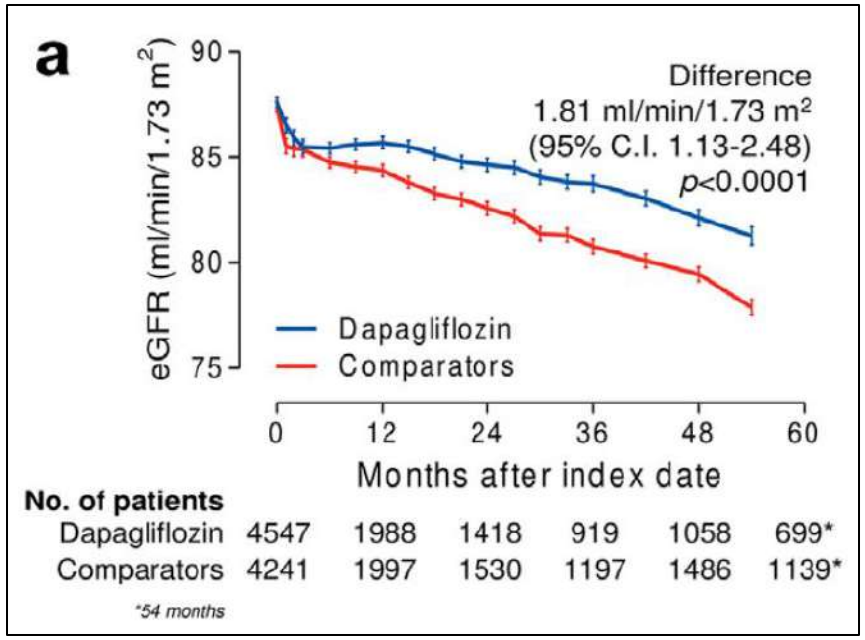
Trial	CREDENCE	DAPA-CKD	EMPA-KIDNEY	DARWIN-Renal
Drug	Canagliflozin	Dapagliflozin	Empagliflozin	Dapagliflozin
Participants, n (active drug/placebo)	4,401 (2,202/2,199)	4,304 (2,152/2,152)	6,609 (3,304/3,305)	12,400 (6,200/6,200)
Median follow-up, years	2.6	2.4	2.0	2.5
T2DM	100%	67.5%	46.0%	100%
eGFR (ml/min/1.73m^2) (active drug/placebo)	56.3/56.0	43.2/43.0	37.4/37.3	87.7/87.4
Renal function at baseline				
Normal (eGFR ≥90)	4.8%	-	-	
Mild impairment (eGFR 60-89)	35.4%	10.5%	21.2% (>45)	93.6% (>60)
Moderate impairment (eGFR 30-59)	55.9%	75.0%	44.3% (30-45)	6.4% (<60)
Severe impairment (eGFR<30)	3.9%	14.5%	34.5%	
Albuminuria at baseline				
Normoalbuminuria	0.7%	-	20.1%	85% (<30)
Microalbuminuria	11.3%	10.3%	28.2%	15% (>30)
Macroalbuminuria	88.0%	89.7 %	51.7%	

Fadini GP et al. Lancet Reg Health Eur. 2024 Feb 1:38:100847.

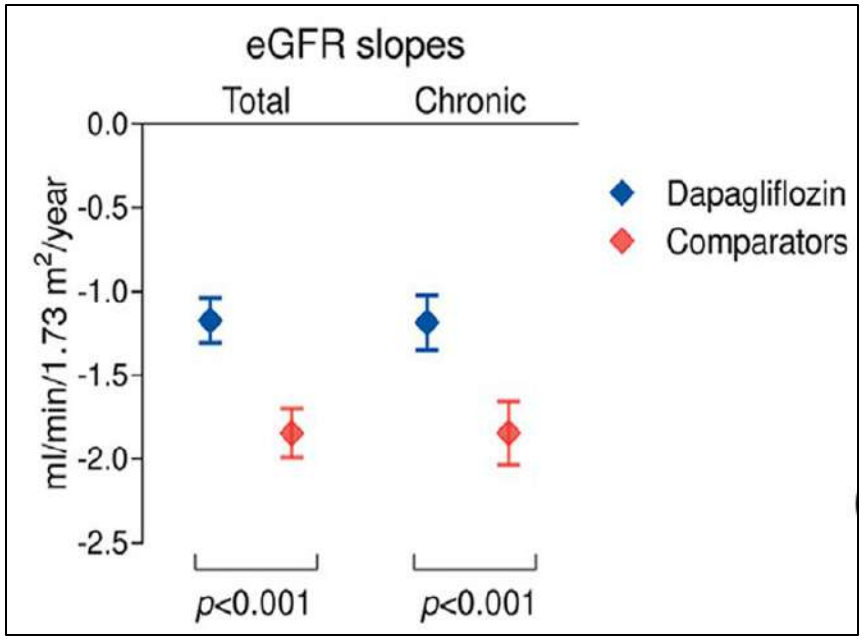
CKD TRIALS WITH SGLT2-i

Long-term benefits of **Dapagliflozin** on renal outcomes of type 2 diabetes under routine care: a comparative effectiveness study on propensity score matched cohorts at low renal risk

DARWIN-Renal



Da un valore basale di 87,5 ml/min/1,73 m2,
eGFR è diminuito significativamente meno tra i nuovi utilizzatori di dapagliflozin
che tra i nuovi utilizzatori di farmaci di confronto.
La **differenza era di 1,81 ml/min/ 1,73 m2**
(95% C.I. 1,13–2,48) a favore di dapagliflozin
(p < 0,0001)



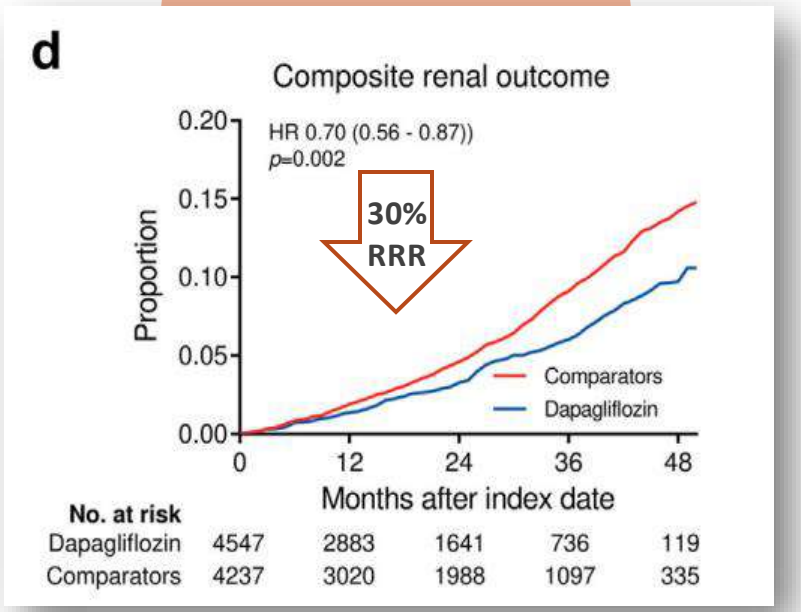
Il **declino medio totale per anno dell'eGFR** è stato
-1,17 ml/min/1,73 m2/anno (95% C.I. -1,03 to -1,31)
nel gruppo dapagliflozin e
-1,84 ml/min/ 1,73 m2/anno (95% C.I. -1,70 to -1,99)
nel gruppo di controllo.
La **differenza era di 0,67 ml/min/1,73 m2/anno (95% C.I. 0,47–0,88)** (p < 0,0001)

Fadini GP et al. Lancet Reg Health Eur. 2024 Feb 1:38:100847.

CKD TRIALS WITH SGLT2-i

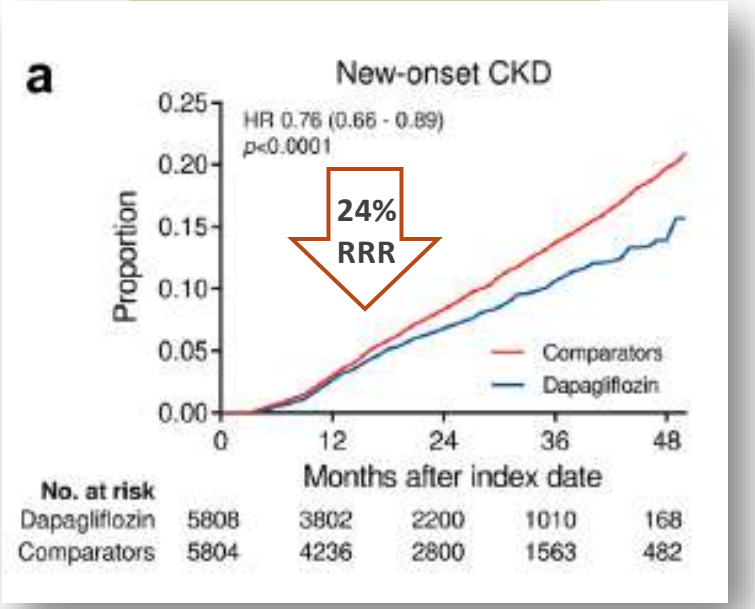
DARWIN-Renal

Outcome renale composito



Endpoint renale composito (perdita del 40% della funzionalità renale, malattia renale allo stadio terminale o dialisi) **è risultato significativamente più basso nel gruppo dapagliflozin**
(HR 0,70; 95% C.I. 0,56 - 0,87; p=0,002)

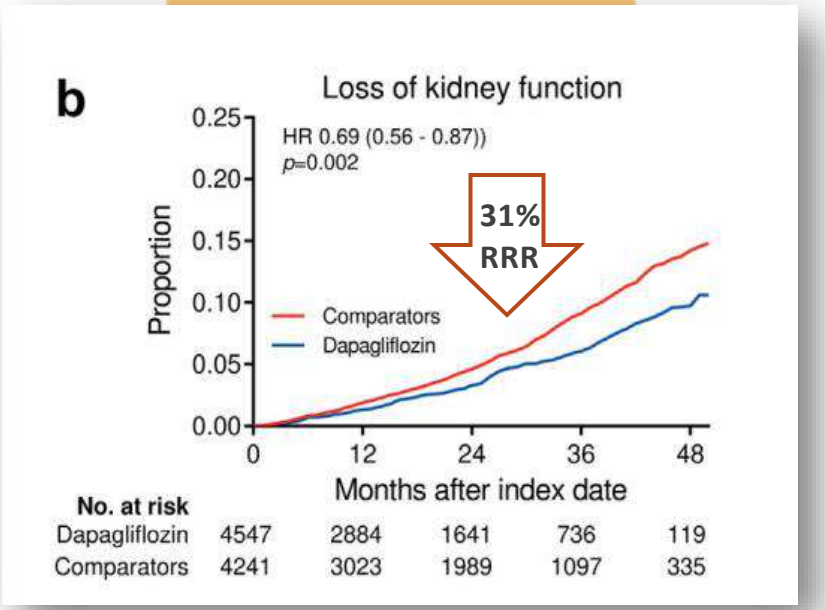
Nuova insorgenza di CKD



I nuovi utilizzatori di dapagliflozin avevano **un tasso più basso di nuova insorgenza di CKD**

(HR 0,76; 95% C.I. 0,66 - 0,89; p<0,001)

Perdita di funzionalità renale



I nuovi utilizzatori di dapagliflozin avevano **minore perdita della funzionalità renale**, definita come >40% di riduzione dell'eGFR

(HR 0,69; 95% C.I. 0,56 - 0,87; p=0,002)

Fadini GP et al. Lancet Reg Health Eur. 2024 Feb 1:38:100847.

TAKE HOME MESSAGES - 1

1 ”vecchie” molecole, vecchie e **nuove** evidenze – *SGLT2-i*

- Le evidenze degli RCT dimostrano una significativa protezione renale da parte degli SGLT2-i nei pazienti con diabete tipo 2 e malattia renale cronica

- La protezione renale indotta dagli SGLT2-i è stata confermata in un’ampia gamma di pazienti, da quelli macroalbuminurici, a quelli con fenotipo non-albuminurico, fino a pazienti a basso rischio renale, in prevenzione primaria

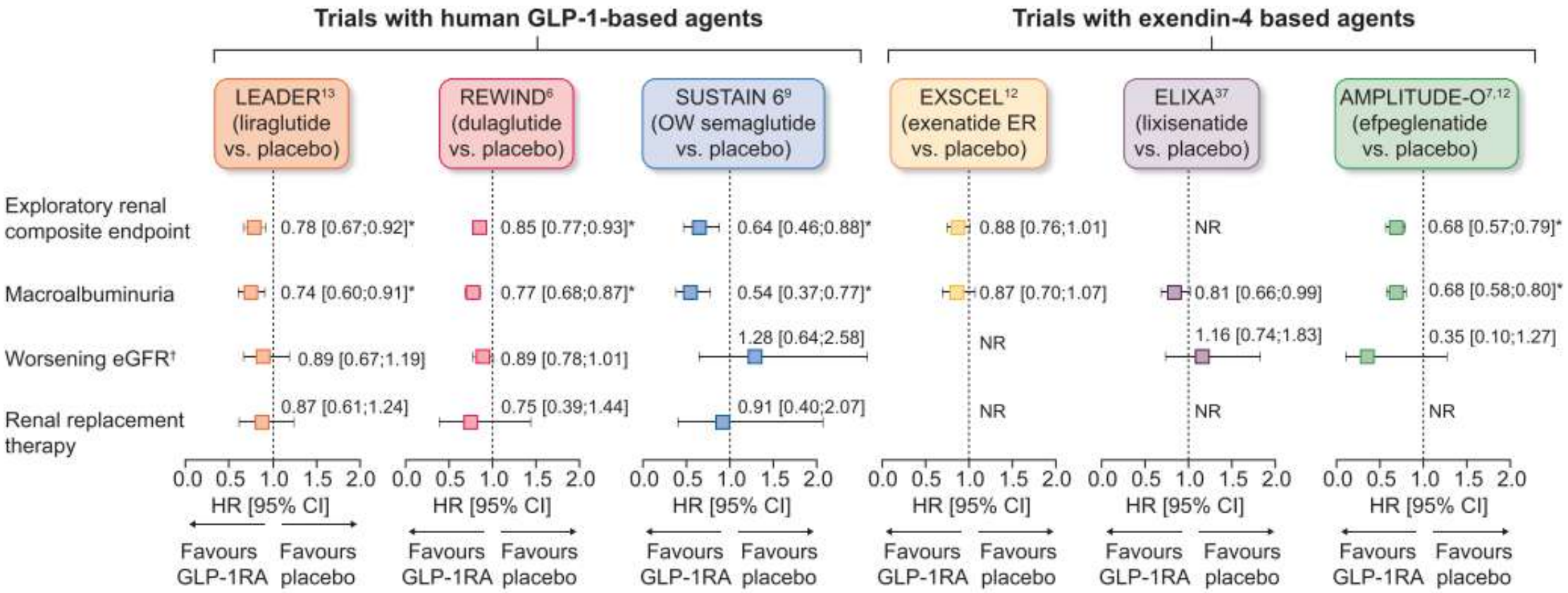
AGENDA

1 "vecchie" molecole, vecchie e **nuove** evidenze – *SGLT2-i*

2 "vecchie" molecole, **nuove** evidenze – *GLP1-RA*

3 **nuove** molecole - *Finerenone*

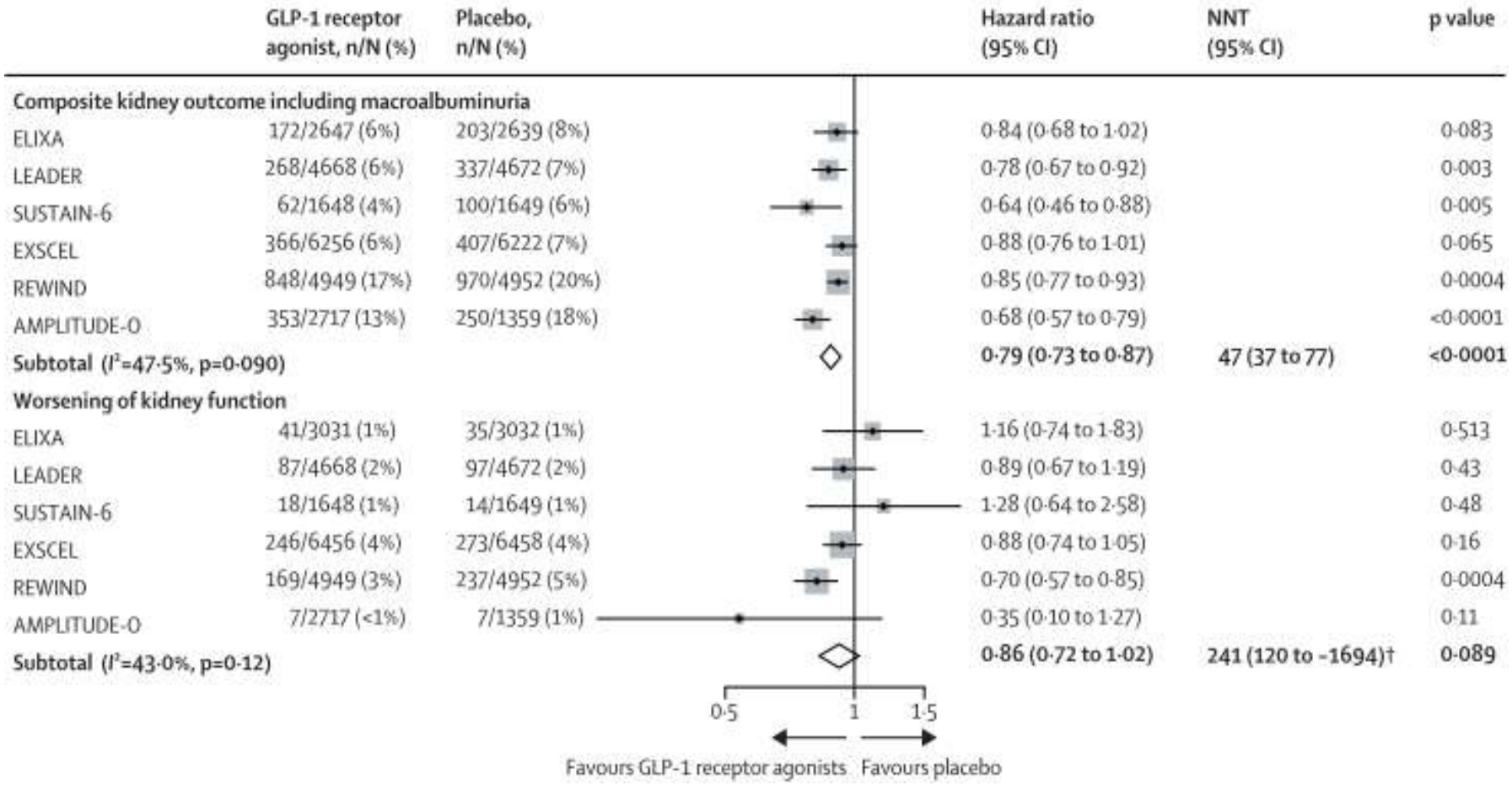
Exploratory kidney outcomes analyses from GLP-1 RA CVOTs



Rossing P et al. Nephrol Dial Transplant. 2023 Aug 31;38(9):2041-2051.

Exploratory kidney outcomes analyses from GLP-1 RA CVOTs

Cardiovascular, mortality, and kidney outcomes with GLP-1 receptor agonists in patients with type 2 diabetes: a systematic review and meta-analysis of randomised trials



Sattar N et al. Lancet Diabetes Endocrinol. 2021 Oct;9(10):653-662.

THE FLOW TRIAL

Methods

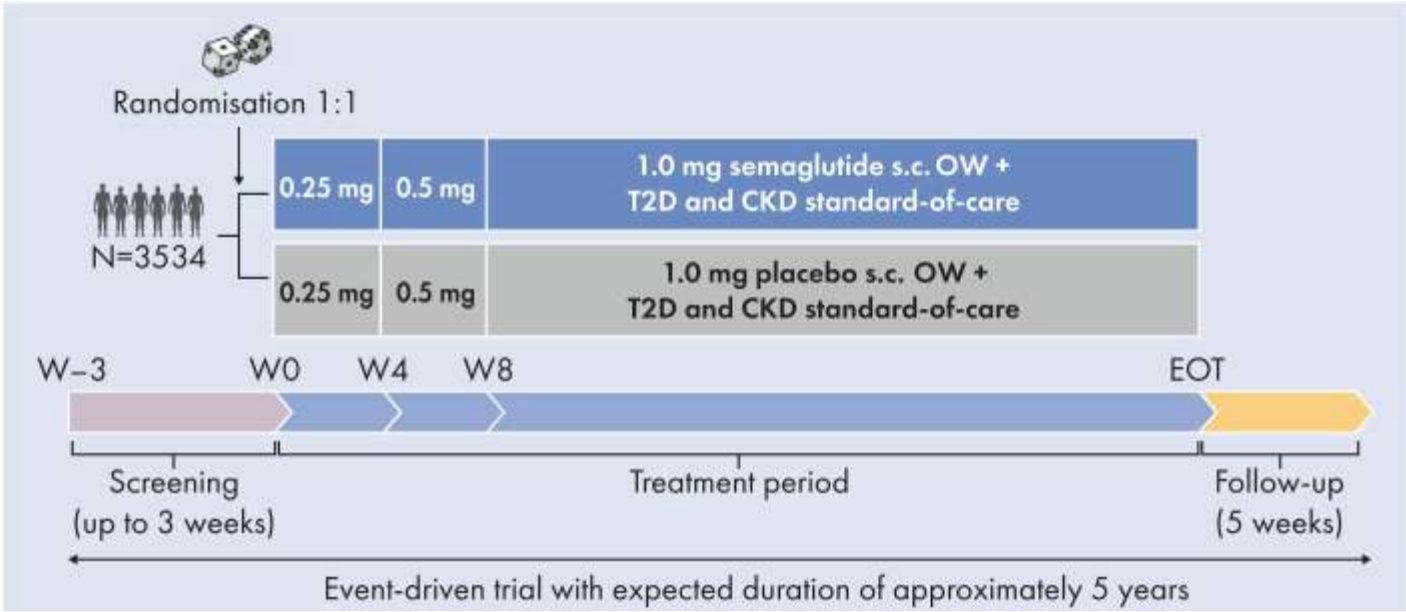
Participants:

- Adults with T2D
- eGFR ≥50 to ≤75 ml/min/1.73 m² and UACR >300 to <5000 mg/g OR
- eGFR ≥25 to <50 ml/min/1.73 m² and UACR >100 to <5000 mg/g

Composite primary endpoint:

Time to first occurrence of:

- Kidney failure (persistent eGFR <15 ml/min/1.73 m² or initiation of CKRT);
- Persistent ≥50% reduction in eGFR; or
- Death from kidney or CV causes



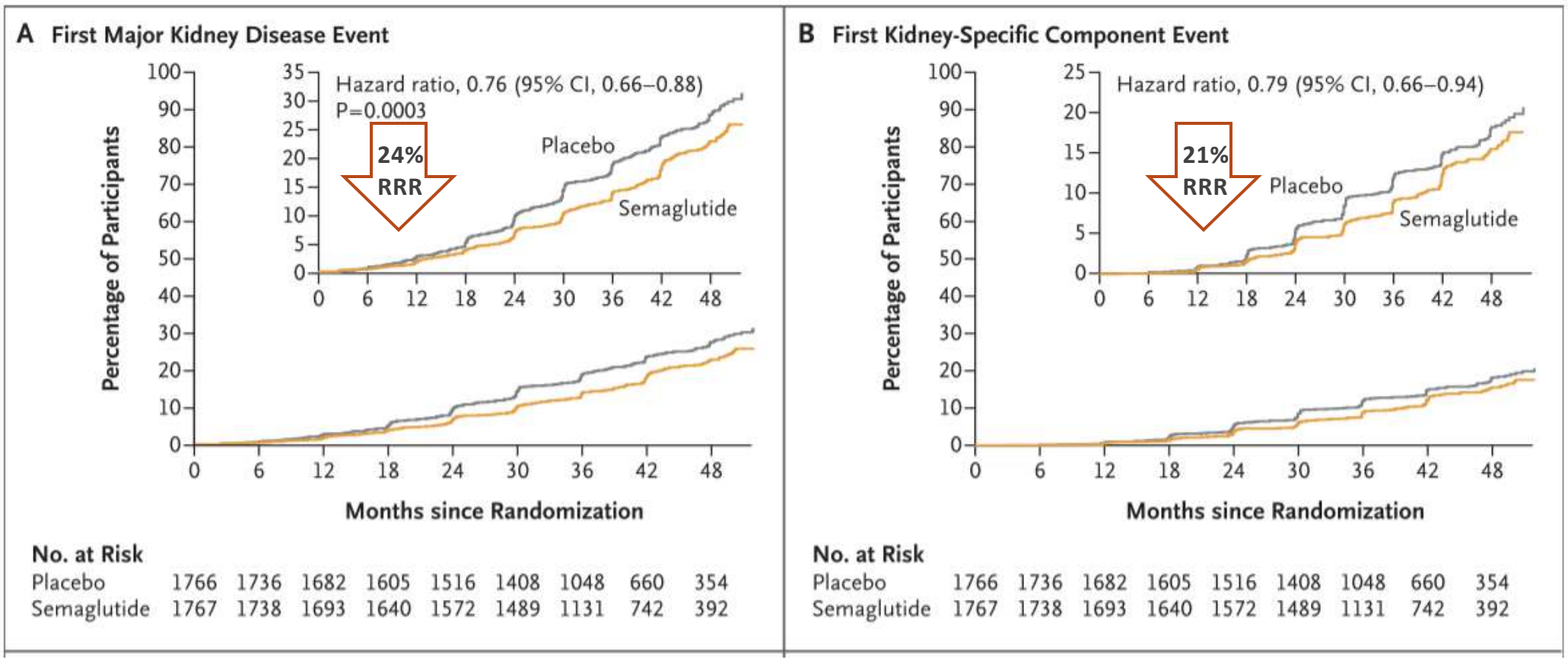
eGFR categories (mL/min/1.73 m²)	UACR categories (mg/g) <30	≥30–<300	≥300
≥90	1 (<0.1)	7 (0.2)	23 (0.6)
≥60–<90	24 (0.7)	173 (4.9)	491 (13.9)
≥45–<60	37 (1.0)	324 (9.2)	694 (19.6)
≥30–<45	40 (1.1)	414 (11.7)	905 (25.6)
≥15–<30	7 (0.2)	97 (2.8)	306 (8.6)
<15	NA	NA	NA

FLOW population

Low risk n=25 (0.7%) Moderate risk n=217 (6.1%) High risk n=878 (24.8%) Very high risk n=2,413 (68.2%)

Rossing P et al. Nephrol Dial Transplant. 2023 Aug 31;38(9):2041-2051.

THE FLOW TRIAL

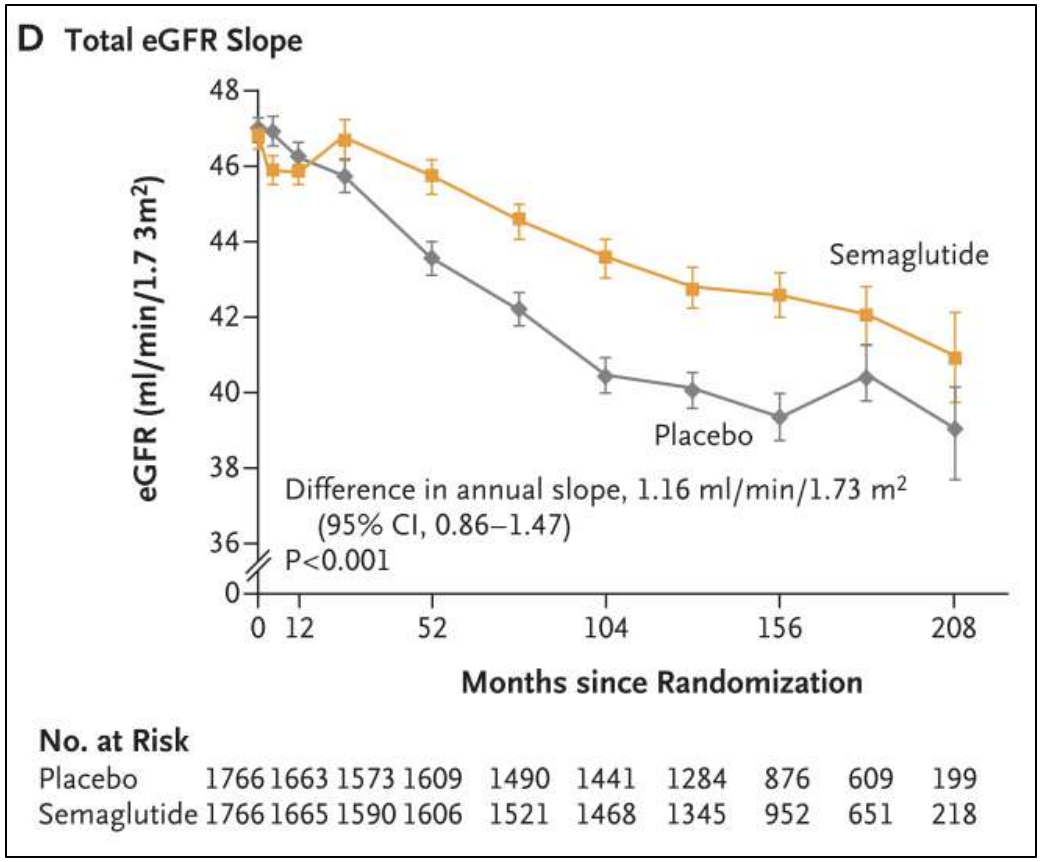


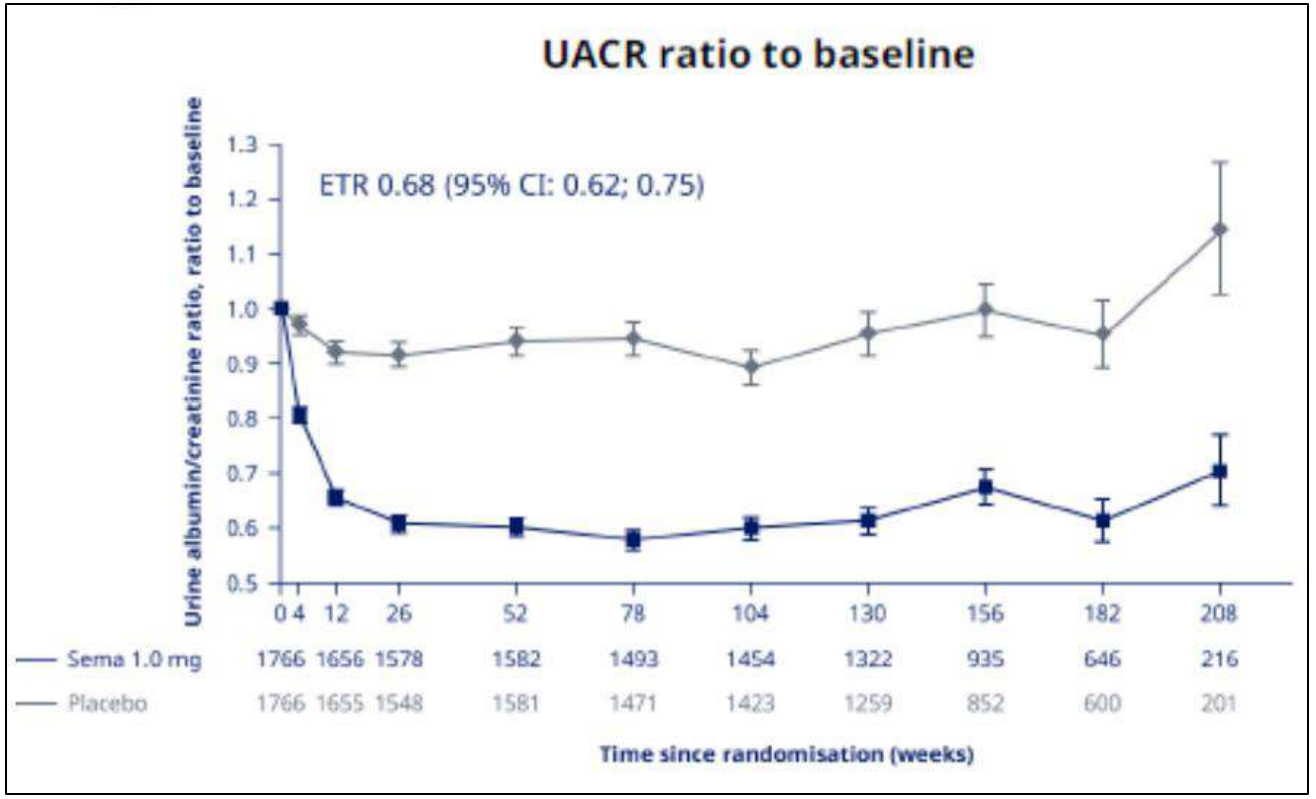
persistent ≥50% reduction in eGFR, ESRD, or death from renal or cardiovascular causes

persistent ≥50% reduction in eGFR, ESRD, or death from renal causes

Perkovic V et al. N Engl J Med. 2024 Jul 11;391(2):109-121.

THE FLOW TRIAL



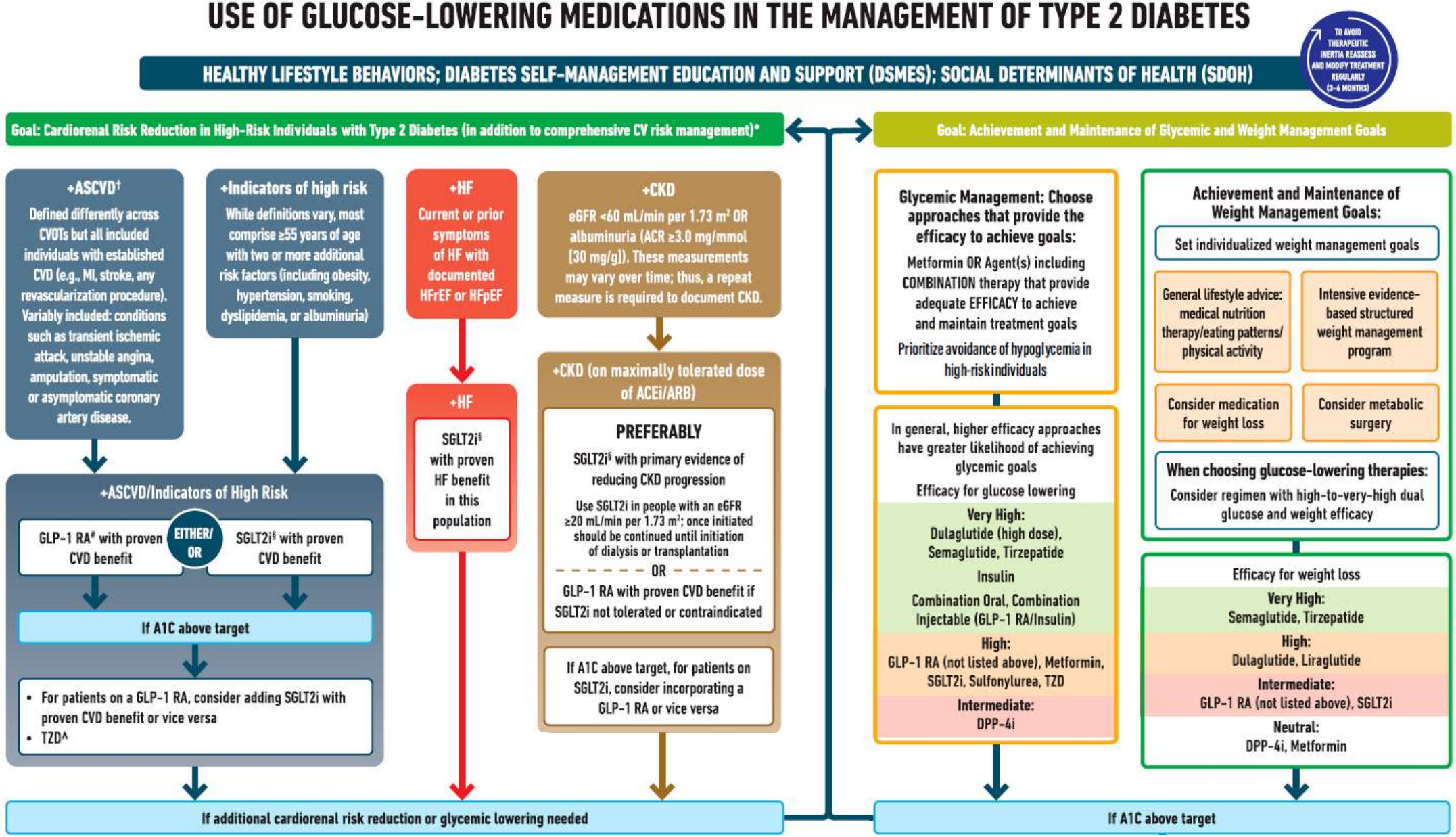


Semaglutide slower loss of kidney function by a mean eGFR of **1.16 mL/min/1.73m2/year**

At 104 weeks, the UACR was reduced by **12%** in the placebo group vs. **40%** in the semaglutide group, for a between-group difference of **32%** (95% CI 25 – 38%)

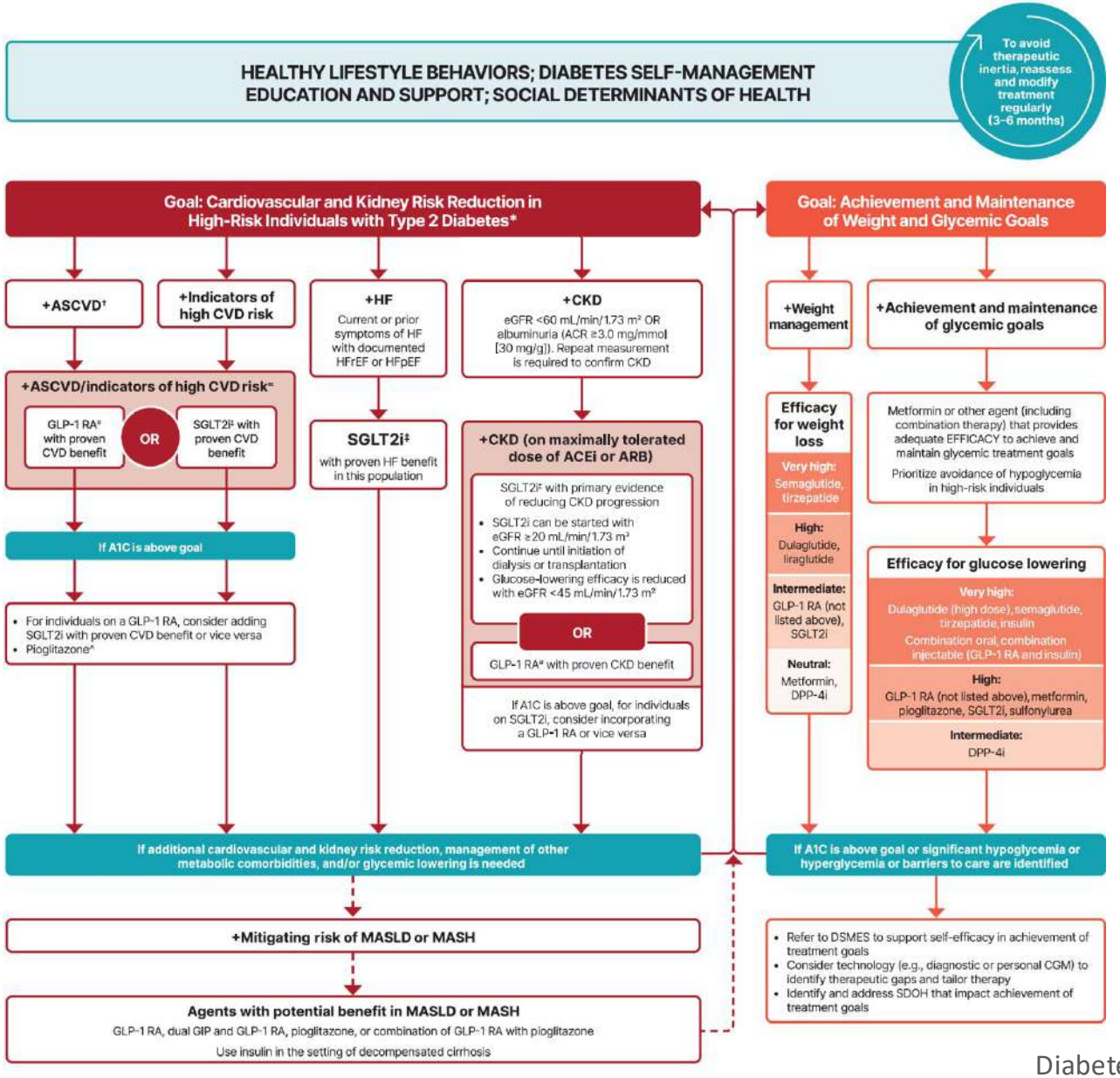
Perkovic V et al. N Engl J Med. 2024 Jul 11;391(2):109-121.

USE OF GLUCOSE-LOWERING MEDICATIONS IN THE MANAGEMENT OF TYPE 2 DIABETES



Diabetes Care 2024;47(Supplement_1):S158–S178

Use of Glucose-Lowering Medications in the Management of Type 2 Diabetes



Diabetes Care 2025;48(Supplement_1):S181–S206

AGENDA

2 ”vecchie” molecole, **nuove** evidenze – *GLP1-RA*

- Lo studio FLOW ha dimostrato che semaglutide riduce il rischio di outcomes renali in pazienti con diabete tipo 2 e malattia renale cronica

AGENDA

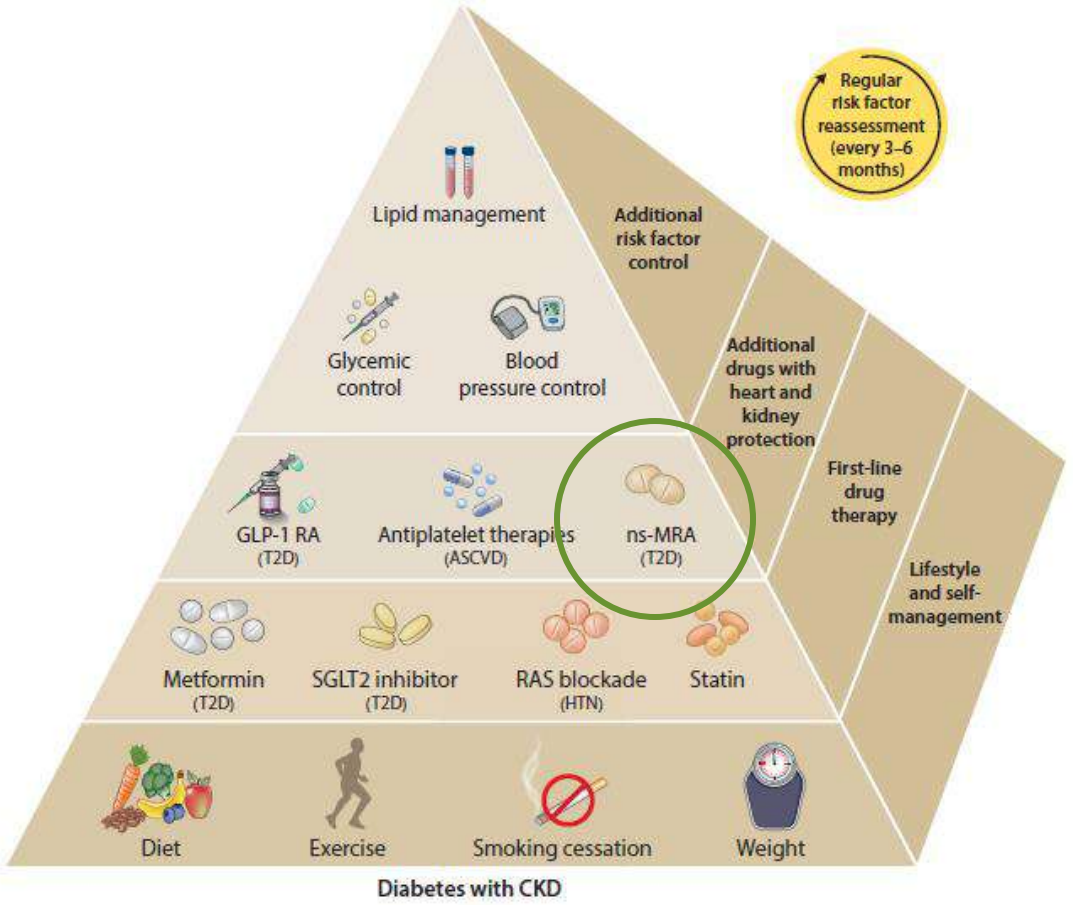
1 "vecchie" molecole, vecchie e **nuove** evidenze – *SGLT2-i*

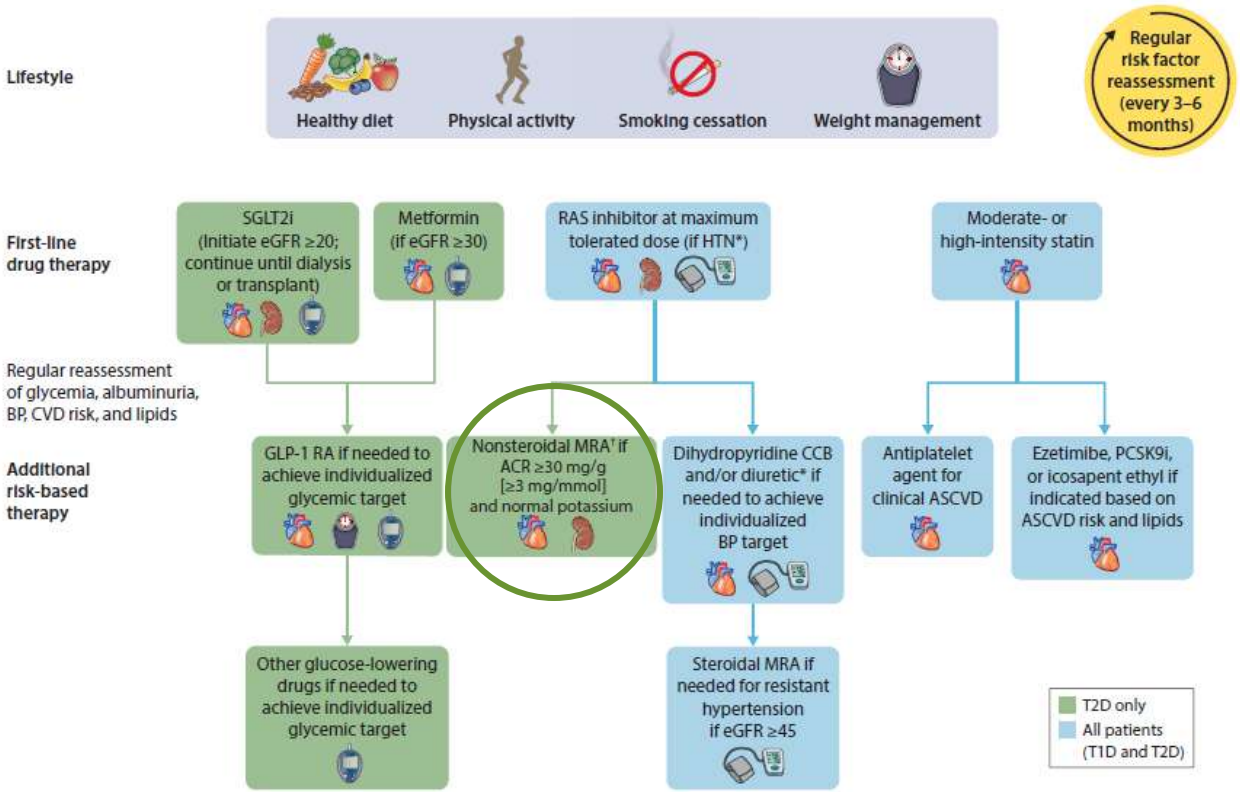
2 "vecchie" molecole, **nuove** evidenze – *GLP1-RA*

3 **nuove** molecole - *Finerenone*

KDIGO 2022

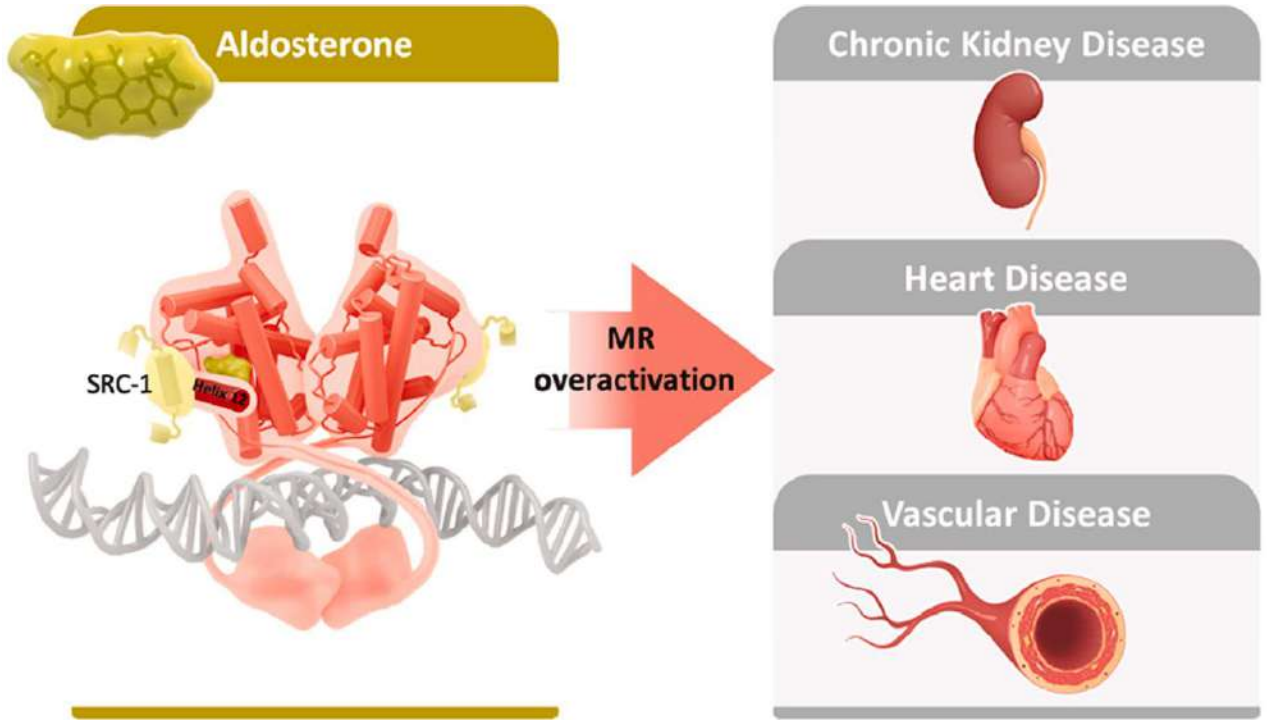
CLINICAL PRACTICE GUIDELINE FOR DIABETES MANAGEMENT IN CHRONIC KIDNEY DISEASE





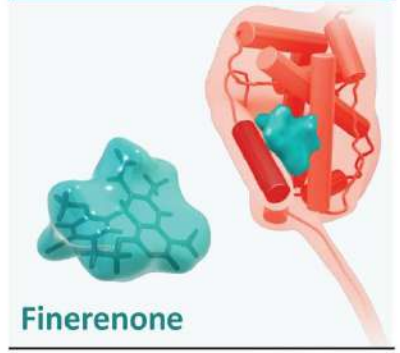
KDIGO Diabetes Work Group. Kidney Int. 2022 Nov;102(5S):S1-S127.

Non-steroidal mineralocorticoid receptor antagonist in cardiorenal disease



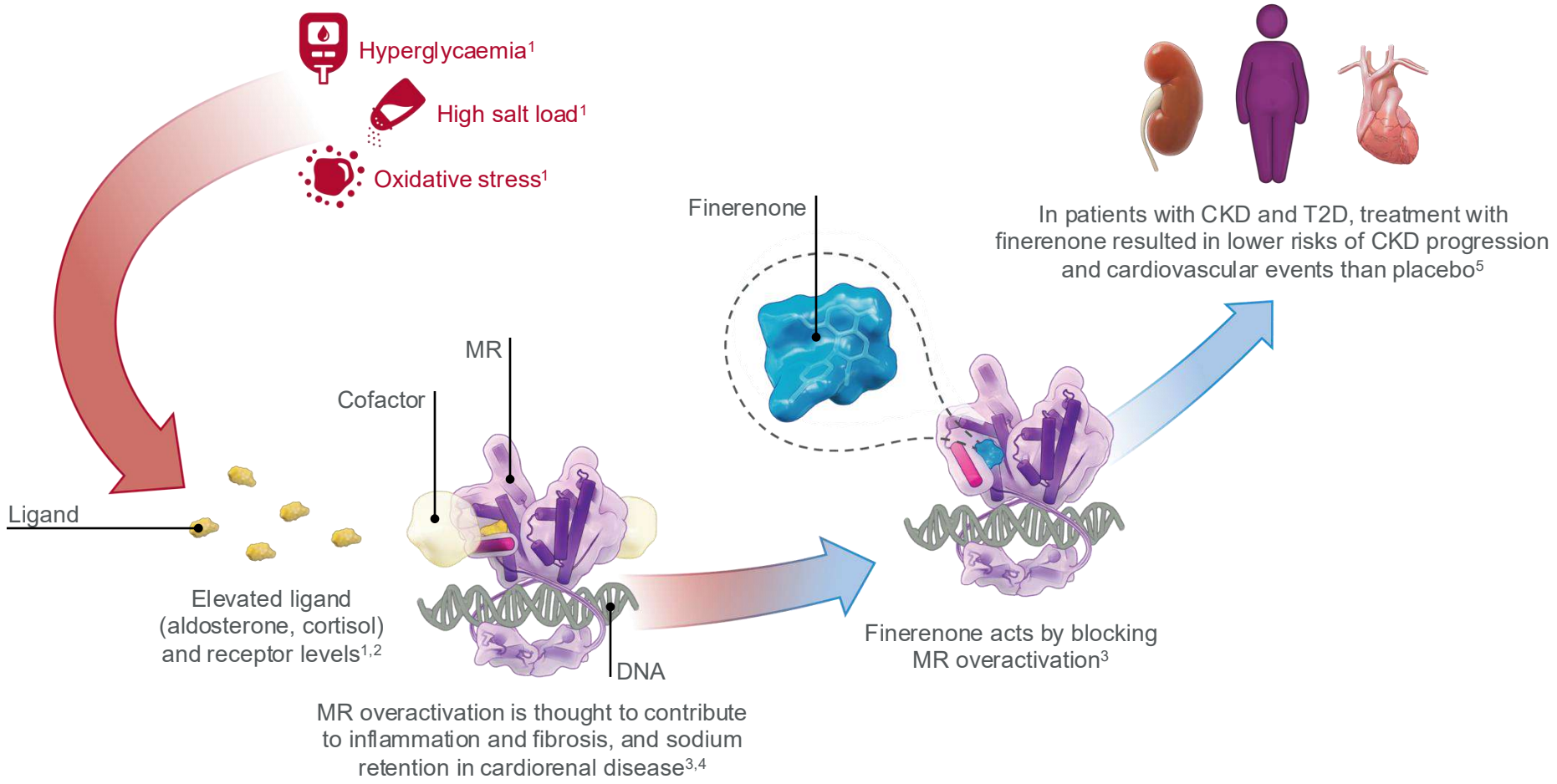
Kolkhof P et al. Pharmacol Res. 2021 Oct;172:105859.

Pharmacokinetic and pharmacodynamic characteristics of MR antagonists

	Steroidal MRAs		Finerenone
	 Spironolactone	 Eplerenone	 Finerenone
Structural properties	Flat (steroidal)	Flat (steroidal)	Bulky (non-steroidal)
Potency to MR	+++	+	+++
Selectivity to MR	+	++	+++
CNS penetration	+	+	–
Sexual side effects	++	(+)	–
Half-life	>20 h**	4–6 h**	2–3 h*
Active metabolites	++	–	–
Effect on BP	+++	++	+

Kintscher U et al. Br J Pharmacol. 2022 Jul;179(13):3220-3234.

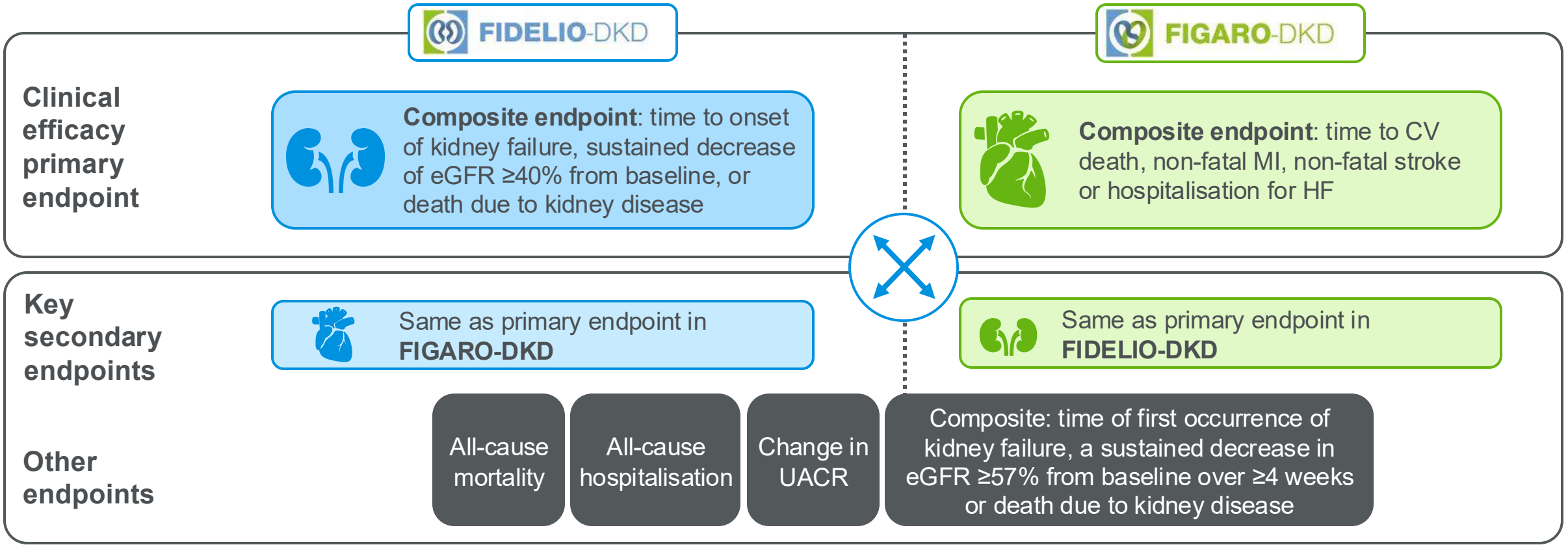
Non-steroidal mineralocorticoid receptor antagonist in cardiorenal disease



1. Buonafine M, *et al. Am J Hypertens* 2018;31:1165–1174; 2. Buglioni A, *et al. Hypertension* 2015;65:45–53; 3. Agarwal R, *et al. Nephrol Dial Transplant* 2020; doi: 10.1093/ndt/gfaa294; 4. Khan NUA & Movahed A. *Rev Cardiovasc Med* 2004;5:71–81; 5. Bakris GL, *et al. N Engl J Med* 2020;383:2219–2229

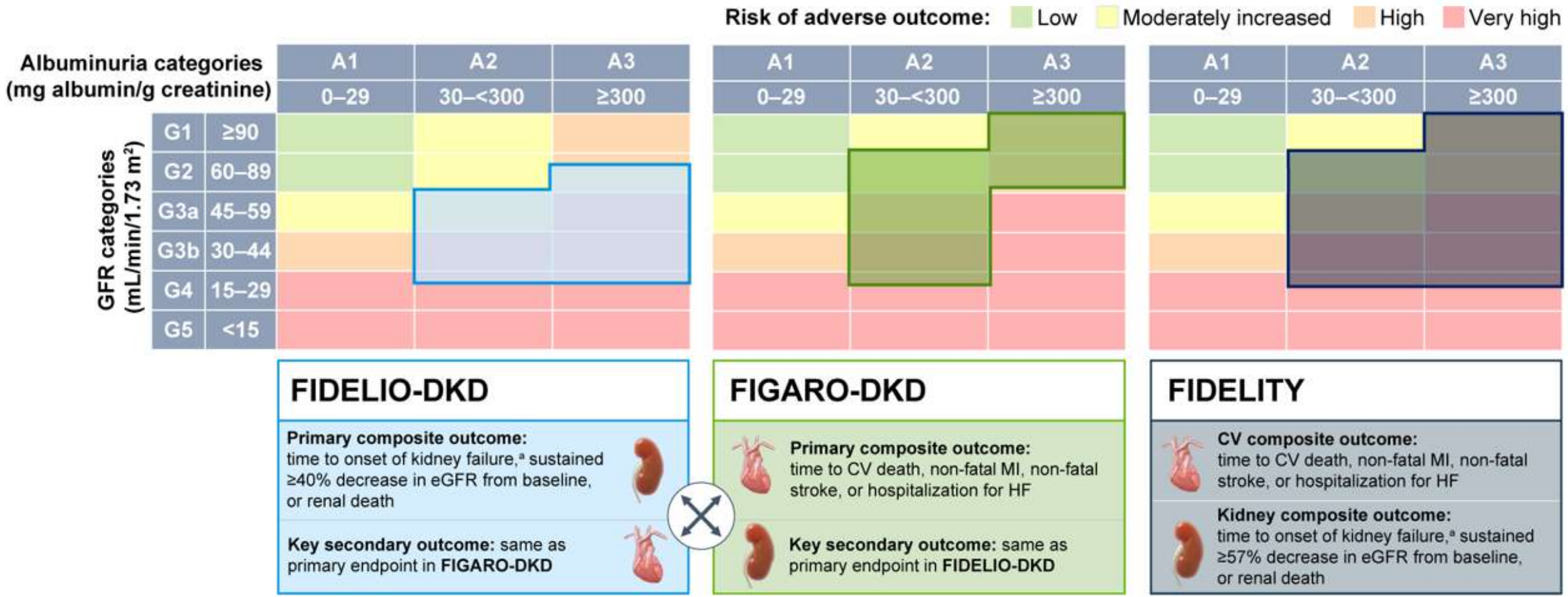
CKD TRIALS WITH FINERENONE

Two phase III trials with complementary kidney and CV endpoints



Bakris GL et al. N Engl J Med. 2020 Dec 3;383(23):2219-2229.; Pitt B et al. N Engl J Med. 2021 Dec 9;385(24):2252-2263.

CKD TRIALS WITH FINERENONE



>13,000 patients **across the disease continuum of CKD and T2D** (CKD stage 1–4) with moderate-to-severely elevated albuminuria (UACR ≥30 mg/g)

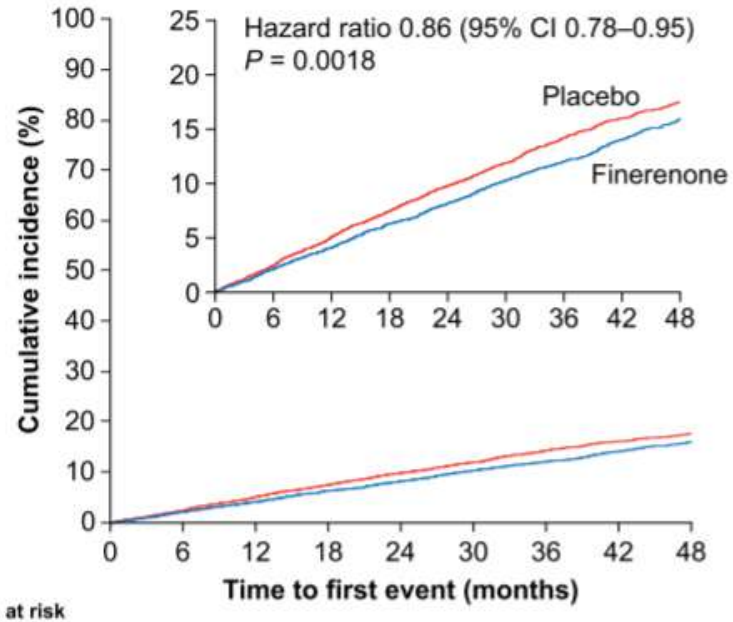
Agarwal R et al. Eur Heart J. 2022 Feb 10;43(6):474-484.

CKD TRIALS WITH FINERENONE

Cardiovascular and kidney outcomes with **Finerenone** in patients with type 2 diabetes and chronic kidney disease: the FIDELITY pooled analysis

FIDELITY

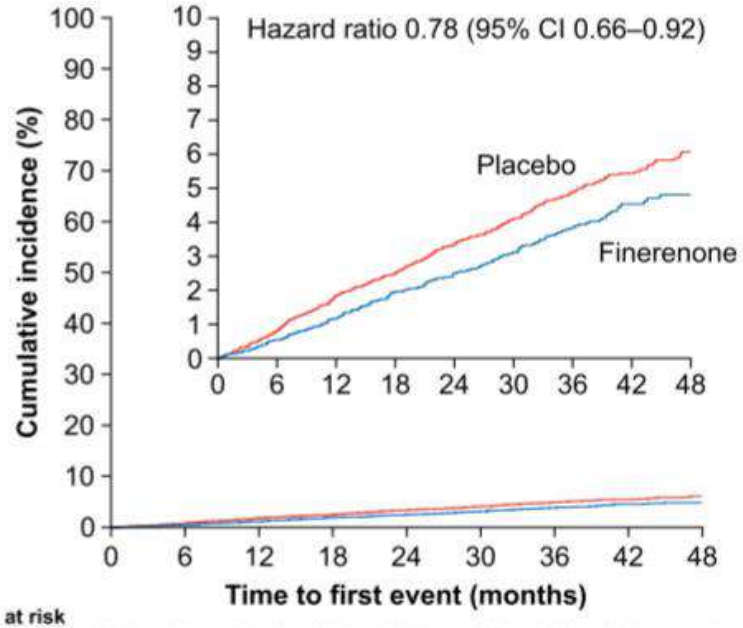
A Composite cardiovascular outcome



No. at risk									
Placebo	6507	6330	6125	5938	5184	4147	2969	2135	1082
Finerenone	6519	6360	6202	6009	5273	4207	3065	2187	1087

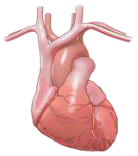
14% RRR

D Hospitalization for heart failure



No. at risk									
Placebo	6507	6394	6246	6103	5379	4342	3138	2271	1144
Finerenone	6519	6431	6313	6168	5450	4379	3203	2299	1143

22% RRR



PRIMARY CV ENDPOINT

Time to CV death, non-fatal MI, non-fatal stroke or hospitalisation for HF

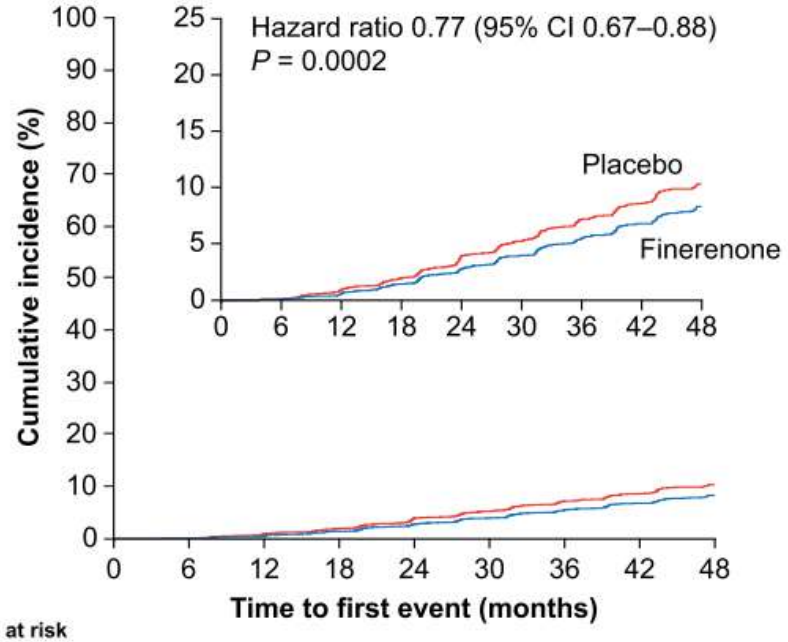
Agarwal R et al. Eur Heart J. 2022 Feb 10;43(6):474-484.

CKD TRIALS WITH FINERENONE

Cardiovascular and kidney outcomes with **Finerenone** in patients with type 2 diabetes and chronic kidney disease: the FIDELITY pooled analysis

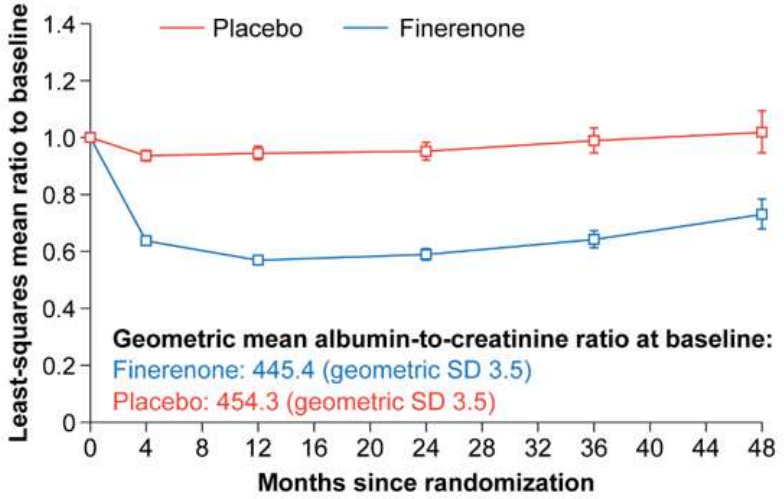
FIDELITY

B eGFR ≥57% composite kidney outcome

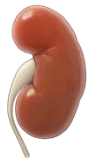


No. at risk									
Placebo	6507	6292	6071	5815	4949	3932	2798	1988	962
Finerenone	6519	6291	6107	5848	5027	3973	2815	2024	959

A Urine albumin-to-creatinine ratio



Number of patients						
Finerenone	6517	6273	5988	4867	2745	899
Placebo	6504	6239	5973	4829	2706	872
Mean change in UACR from baseline (%)						
Finerenone	Ref	–36%	–43%	–41%	–36%	–27%
Placebo	Ref	–6%	–6%	–5%	–1%	+2%



KEY SECONDARY KIDNEY ENDPOINT

Time to kidney failure, sustained ≥57% decrease in from baseline or renal death

23% RRR

UACR

ratio of LS mean change from baseline 0.68 (95% CI 0.66–0.70)

32% RRR

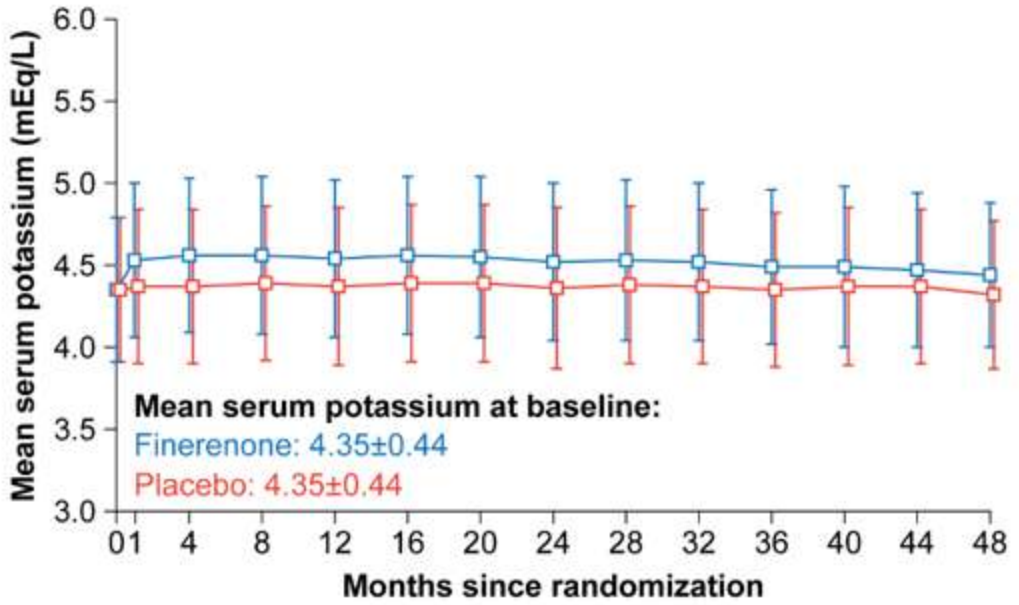
Agarwal R et al. Eur Heart J. 2022 Feb 10;43(6):474-484.

CKD TRIALS WITH FINERENONE

Cardiovascular and kidney outcomes with **Finerenone**
in patients with type 2 diabetes and chronic kidney disease: the FIDELITY pooled analysis

FIDELITY

B **Mean serum potassium**



Number of patients						
Finerenone	6510	6234	5990	4916	2781	912
Placebo	6487	6229	5965	4878	2759	887
Mean change in serum potassium from baseline (mEq/L)						
Finerenone	Ref	0.21	0.20	0.18	0.17	0.13
Placebo	Ref	0.02	0.02	0.02	0.03	0.03

Agarwal R et al. Eur Heart J. 2022 Feb 10;43(6):474-484.

Prescrizione – aspetti pratici

Indicazione ammessa alla rimborsabilità: K[redacted] è indicato per il trattamento dei pazienti adulti con malattia renale (stadi 3 e 4 con albuminuria) associata a diabete mellito di tipo 2, in trattamento con ACEi/ARB alla massima dose tollerata e che presentino una delle seguenti condizioni:
1) controindicazione o intolleranza agli inibitori SGLT2;
2) comprovata evidenza di persistente albuminuria e/o rapido declino funzionale renale (perdita di eGFR ≥3 mL/min/anno), nonostante il trattamento con inibitori SGLT2

1. **REGISTRARE I DATI DEL PAZIENTE**
   a. Centro prescrittore
   b. Nome e cognome medico prescrittore
   c. Dati anagrafici del paziente
   d. ASL di residenza
   e. Nome e cognome dell'MMG
   f. Codice ASL MMG

2. **REGISTRARE I DATI CLINICI PER L'ELEGGIBILITÀ DEL PAZIENTE**
   a. eGFR ≥ 25 < 60 mL/min/1,73 m^2
   b. UACR ≥ 30 mg/g
   c. Potassio sierico ≤ 5 mmol/L
   d. T2D
   e. Trattamento stabile ACEi/ARBs da almeno 4 settimane
   f. SGLT2i si vs no – specificare perché
   g. Trattamento concomitante con potenti inibitori CYP3A4 o MRA o diuretici risparmiatori di potassio
   h. Paziente affetto da Morbo di Addison
   i. Compromissione Funzionalità epatica

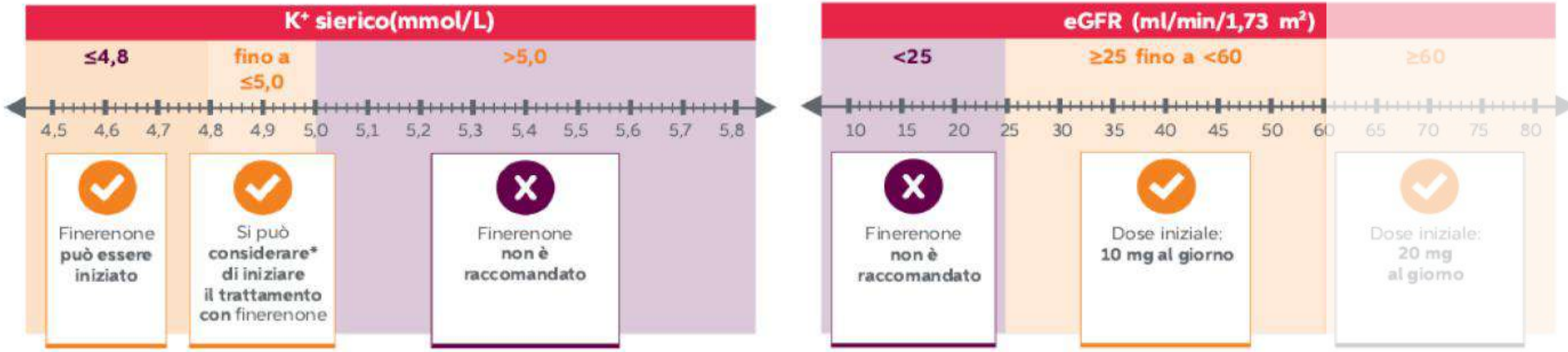
3. **PIANO TERAPEUTICO**
   a. Durata (6 mesi per la prima prescrizione)
   b. Posologia (10 mg)

Prescrizione – aspetti pratici

Inizio del trattamento [redacted]

È necessario misurare preventivamente il potassio sierico e la velocità di filtrazione glomerulare stimata (eGFR) per poter stabilire se il trattamento con finerenone possa essere iniziato e determinarne la dose iniziale.

Nei pazienti con eGFR <25 mL/min/1,73 m^2 il trattamento con finerenone non deve essere iniziato a causa di dati clinici limitati (vedere paragrafi 4,4 e 5,2).



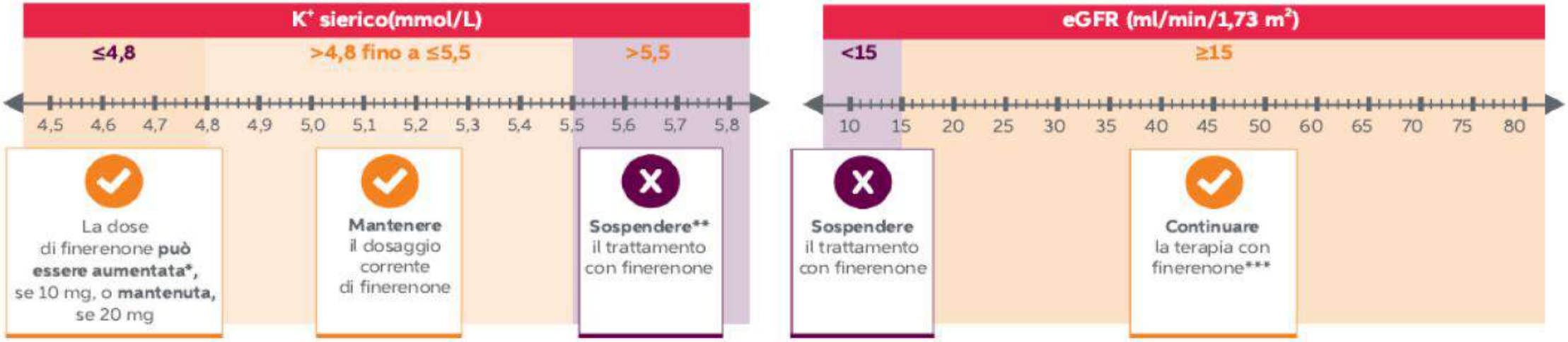
Proseguimento del trattamento [redacted]

Potassio sierico ed eGFR devono essere nuovamente misurati **4 settimane dopo l'inizio o il riavvio del trattamento con finerenone o dopo un incremento della dose.** Successivamente, il potassio sierico deve essere nuovamente misurato regolarmente e al bisogno in base alle caratteristiche del paziente e ai livelli di potassio sierico.

Nei pazienti con eGFR ≥15 mL/min/1,73 m², il trattamento con finerenone può essere proseguito con aggiustamenti della dose in base ai livelli di potassio sierico.

L'eGFR deve essere misurato **4 settimane dopo l'inizio del trattamento** per stabilire se la dose iniziale possa essere aumentata alla dose giornaliera raccomandata di 20 mg.

A causa di dati clinici limitati, il trattamento con finerenone deve essere interrotto nei pazienti con malattia renale giunta allo stadio terminale (eGFR <15 mL/min/1,73 m²) (vedere paragrafo 4,4).



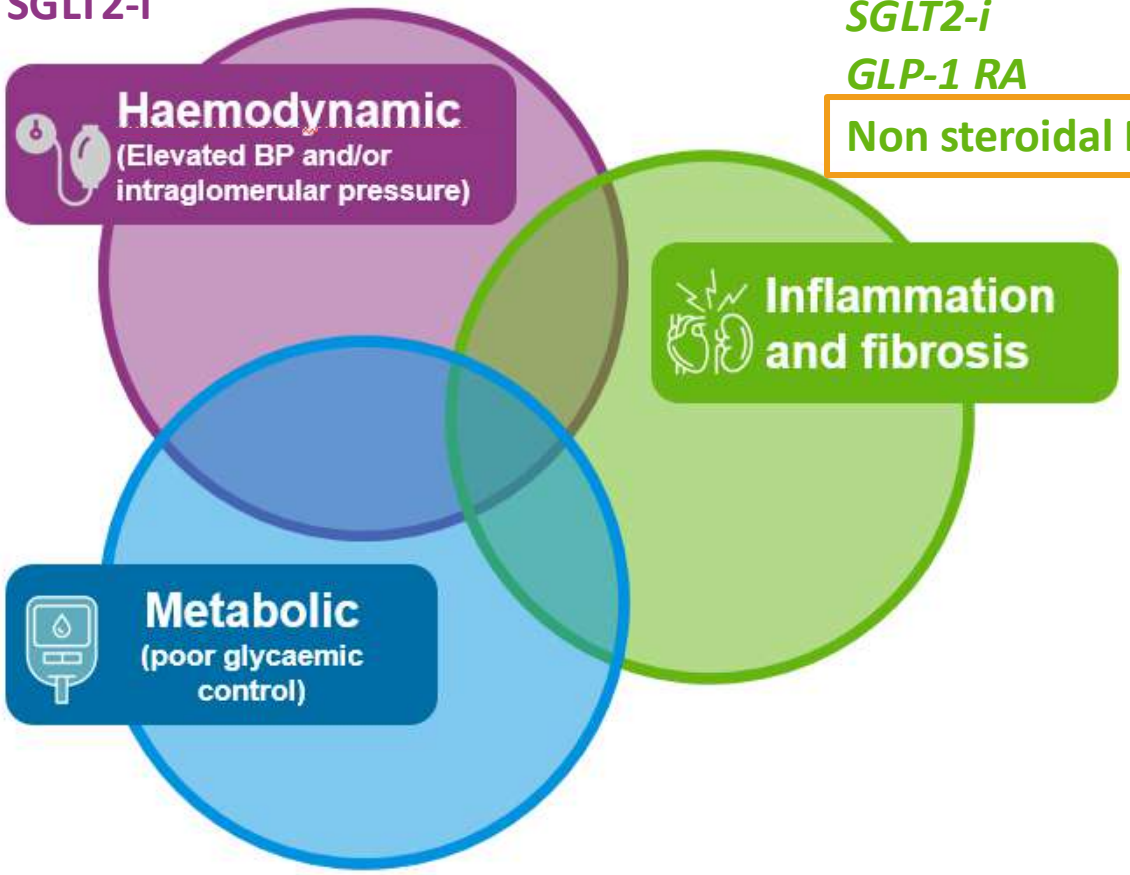
AGENDA

3 **nuove** molecole - *Finerenone*

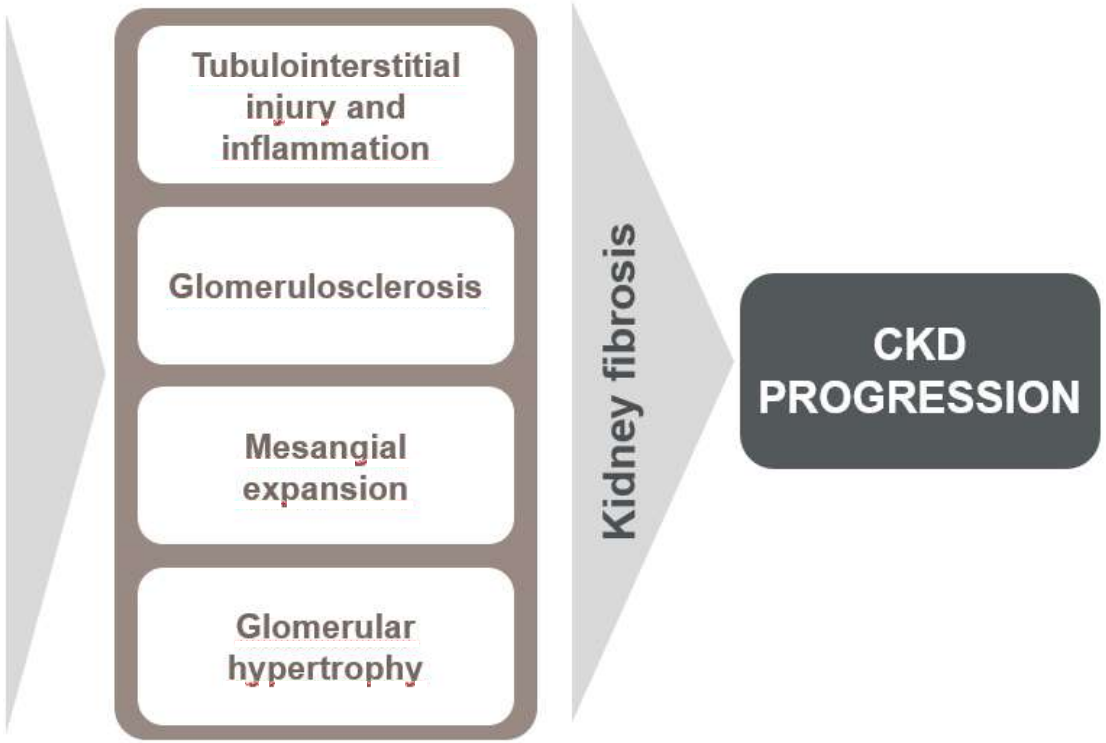
- Finerenone riduce il rischio di progressione della malattia renale cronica e nei pazienti con diabete tipo 2 e albuminuria residua

TAKE HOME MESSAGE

Non steroidal MRA
RAS blockers
SGLT2-i



RAS blockers
SGLT2-i
GLP-1 RA
Non steroidal MRA



Glucose-lowering agents
SGLT2-i
GLP-1 RA

Alicic RZ et al. Clin J Am Soc Nephrol. 2017;12:2032–2045
Mora-Fernández C et al. J Physiol. 2014;18:3997

TAKE HOME MESSAGE

The *four pillars* of cardiorenal protection in people with CKD and T2D

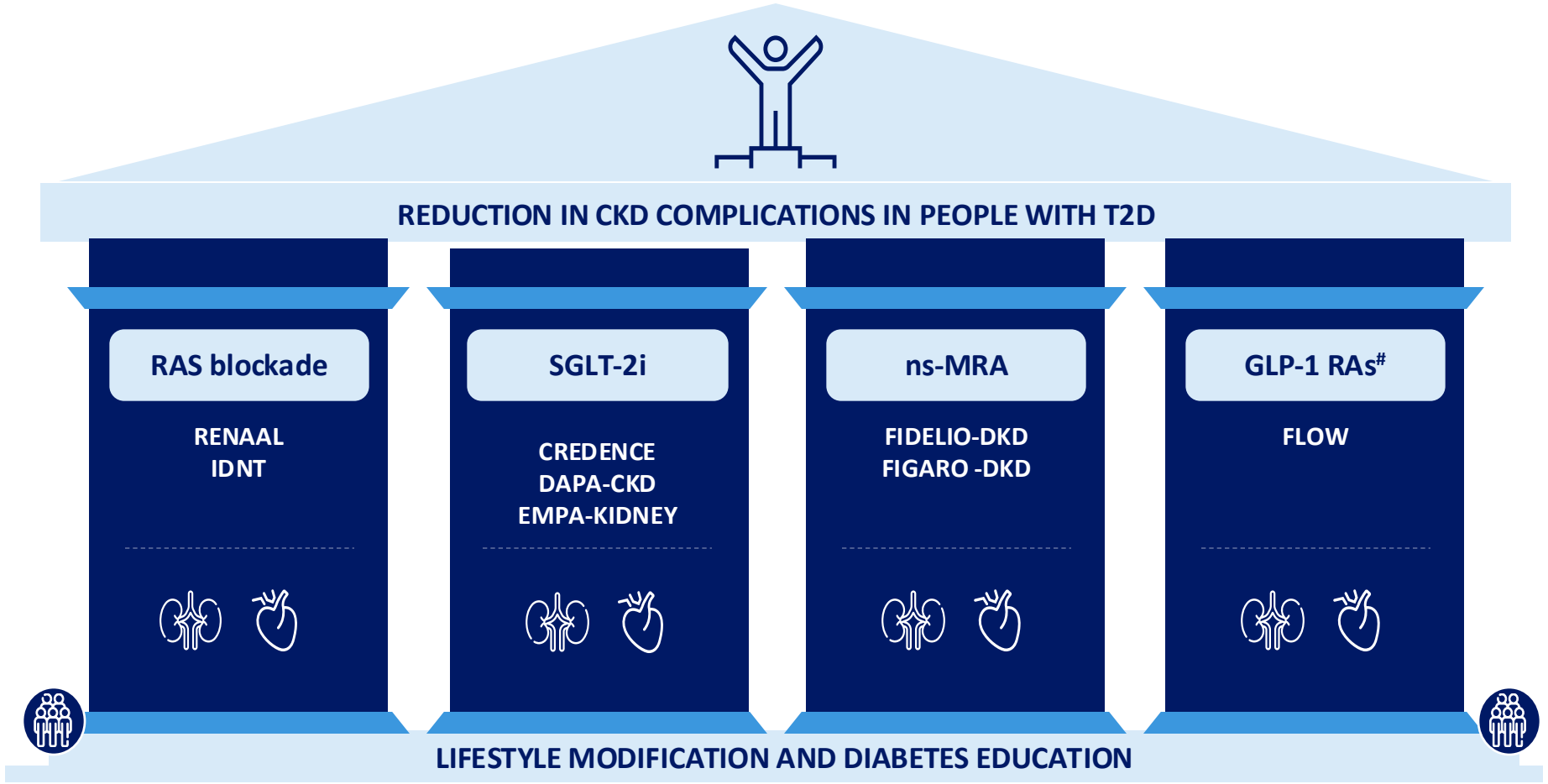


Figure design adapted from: 2023 ADA, Standards of Medical Care in Diabetes - 2023: Diabetes Care, December 2022, Vol.46, Supplement 1