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Finerenone in Asian patients with chronic kidney disease: A FIND-CKD analysis

Masaomi Nangaku,[1] Rajiv Agarwal,[2] David Z. I. Cherney,[3] Carolyn S. P. Lam,[4,5] Brendon L. Neuen,[6,7] Vlado Perkovic,[7] Katherine R. Tuttle,[8] Pantelis Sarafidis,[9] Meike Brinker,[10] Hiddo J. L. Heerspink[6,11]
on behalf of the FIND-CKD investigators

[1]Division of Nephrology and Endocrinology, The University of Tokyo Graduate School of Medicine, Tokyo, Japan; [2]Division of Nephrology, Richard L. Roudebush VA Medical Center, Indianapolis, Indiana University School of Medicine, Indianapolis, IN, USA; [3]Division of Nephrology, University Health Network, Toronto General Hospital, University of Toronto, Toronto, ON, Canada; [4]National Heart Centre Singapore, Singapore; [5]Duke-National University of Singapore Medical School, Singapore; [6]Renal and Metabolic Division, George Institute for Global Health, University of New South Wales, Sydney, NSW, Australia; [7]Department of Renal Medicine, Royal North Shore Hospital, Sydney, NSW, Australia; [8]Providence Inland Northwest Health, University of Washington School of Medicine, Spokane, WA, USA; [9]1st Department of Nephrology, Aristotle University of Thessaloniki, Hippokration Hospital, Thessaloniki, Greece; [10]Cardiology and Nephrology Clinical Development, Bayer AG, Wuppertal, Germany; [11]Department of Clinical Pharmacy and Pharmacology, University of Groningen, University Medical Center Groningen, Groningen, Netherlands

Corresponding author: Professor Masaomi Nangaku, Division of Nephrology, Division of Nephrology and Endocrinology, The University of Tokyo Graduate School of Medicine, Tokyo, Japan, mnangaku@m.u-tokyo.ac.jp

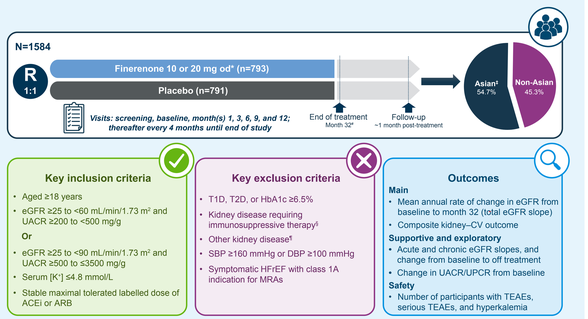
Background

- Over 400 million adults in Asia have chronic kidney disease (CKD), with numbers projected to rise further with increasing rates of diabetes, hypertension, and aging populations[1–4]
- Nondiabetic causes of CKD, including glomerulonephritis (e.g. immunoglobulin A nephropathy), account for a high CKD incidence in developing Asian regions[1,3]
- Considering that Asia comprises 60% of the global population,[1] effective treatments for CKD are needed to address the growing healthcare and socioeconomic impact of nondiabetic CKD across the region
- In the phase III randomized, double-blind, global, placebo-controlled, multicenter FIND-CKD trial (NCT05047263), treatment with the nonsteroidal mineralocorticoid receptor antagonist finerenone was associated with a slower annual rate of estimated glomerular filtration rate (eGFR) decline from baseline to month 32 and reduced risks of kidney and cardiovascular (CV) outcomes compared with placebo in adults with nondiabetic CKD[5]
- The aim of this prespecified FIND-CKD subanalysis was to assess the effects of finerenone on efficacy and safety outcomes in Asian participants with nondiabetic CKD

Methods

- FIND-CKD randomized adults with nondiabetic CKD (eGFR ≥25 to <90 mL/min/1.73 m^2 and urinary albumin-to-creatinine ratio [UACR] ≥200 to ≤3500 mg/g) treated with an optimized dose of renin–angiotensin system inhibitor to finerenone (10 or 20 mg oral) or placebo[6]
- The study design, inclusion and exclusion criteria, and outcomes are shown in **Figure 1**
- All outcomes were analyzed according to Asian and non-Asian subpopulations
  - The Asian subpopulation included participants who self-identified as Asian irrespective of their location
  - Participants who did not self-identify as Asian were categorized as non-Asian

Figure 1. FIND-CKD study design



*For 10 mg od: eGFR ≥25 to <60 mL/min/1.73 m^2; for 20 mg od: eGFR ≥60 mL/min/1.73 m^2; †participants remained in the study until the last randomized participant reached 32 months of treatment; ‡including participants randomized from sites in Asian countries and territories (China, [Mainland China, Hong Kong and Taiwan], India, Japan, Malaysia, Singapore, and South Korea) and from countries outside Asia; §lupus nephritis, anti-neutrophil cytoplasmic antibody–associated vasculitis or any other kidney disease within 6 months prior to screening; ¶known autosomal recessive or dominant polycystic kidney disease

ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; CV, cardiovascular; DBP, diastolic blood pressure; eGFR, estimated glomerular filtration rate; HbA1c, glycated hemoglobin; HFrEF, heart failure with reduced ejection fraction; [K+], potassium concentration; MRA, mineralocorticoid receptor antagonist; od, once daily; R, randomized; SBP, systolic blood pressure; T1D, type 1 diabetes; T2D, type 2 diabetes; TEAE, treatment-emergent adverse event; UACR, urinary albumin-to-creatinine ratio; UPCR, urinary protein-to-creatinine ratio

Results

Baseline characteristics

- Of 1584 participants in FIND-CKD, 867 (54.7%) self-identified as Asian (finerenone: n=447/867 [51.6%]; placebo: n=420/867 [48.4%])
- Overall, baseline characteristics were balanced between treatment arms and in the Asian and non-Asian subpopulations (**Table 1**)
  - Compared with non-Asian participants, Asian participants were, on average, younger; had a lower mean body mass index; were more likely to use angiotensin receptor blockers; and were less likely to use angiotensin-converting enzyme inhibitors and diuretics
  - A greater proportion of non-Asian participants had a history of atherosclerotic CV disease and hypertension, whereas the Asian subpopulation had higher rates of chronic glomerulonephritis

Table 1. Baseline characteristics in the Asian and non-Asian subpopulations treated with finerenone or placebo

	Asian (n=867)		Non-Asian (n=717)	
Characteristics	**Finerenone (n=447)**	**Placebo (n=420)**	**Finerenone (n=346)**	**Placebo (n=371)**
Age, years, mean ± SD	52.8 ± 13.6	52.2 ± 13.8	56.8 ± 14.7	57.8 ± 14.4
Sex, male, n (%)	280 (62.6)	265 (63.1)	238 (68.8)	266 (71.7)
Race, n (%)				
Asian	447 (100.0)	420 (100.0)	0 (0)	1 (0.3)*
White	0 (0)	0 (0)	308 (89.0)	340 (91.6)
Black	0 (0)	0 (0)	22 (6.4)	15 (4.0)
Other#	0 (0)	0 (0)	16 (4.6)	15 (4.0)
BMI, kg/m^2, mean ± SD	26.2 ± 5.0	25.9 ± 4.6	29.7 ± 5.9	29.3 ± 6.0
Serum [K+], mmol/L, mean ± SD	4.4 ± 0.4	4.4 ± 0.4	4.5 ± 0.5	4.5 ± 0.5
eGFR, mL/min/1.73 m^2, mean ± SD	47.3 ± 16.3	47.1 ± 16.1	46.1 ± 16.1	46.1 ± 15.9
UACR, mg/g, median (Q1–Q3)	826.9 (581.2–1241.5)	784.1 (590.4–1186.3)	828.1 (558.9–1272.0)	838.2 (565.8–1260.7)
SBP, mmHg, mean ± SD	129.2 ± 14.3	127.9 ± 14.9	130.4 ± 13.3	130.8 ± 13.3
Medical history, n (%)				
ASCVD	37 (8.3)	45 (10.7)	53 (15.3)	60 (16.2)
Hypertension	386 (86.4)	361 (86.0)	315 (91.0)	345 (93.0)
Heart failure	6 (1.3)	4 (1.0)	10 (2.9)	15 (4.0)
Primary cause of CKD, n (%)				
Hypertensive/ischemic nephropathy	93 (20.8)	95 (22.6)	141 (40.8)	130 (35.0)
Chronic glomerulonephritis	289 (64.7)	268 (63.8)	157 (45.4)	189 (50.9)
Medication use, n (%)				
SGLT-2i	64 (14.3)	62 (14.8)	70 (20.2)	74 (19.9)
ACEi	73 (16.3)	60 (14.3)	157 (45.4)	145 (39.1)
ARB	373 (83.4)	360 (85.7)	187 (54.0)	225 (60.6)
Diuretics	36 (8.1)	39 (9.3)	106 (30.6)	109 (29.4)
Beta blocker	89 (19.9)	79 (18.8)	112 (32.4)	134 (36.1)
Statin	231 (51.7)	225 (53.6)	185 (53.5)	232 (62.5)

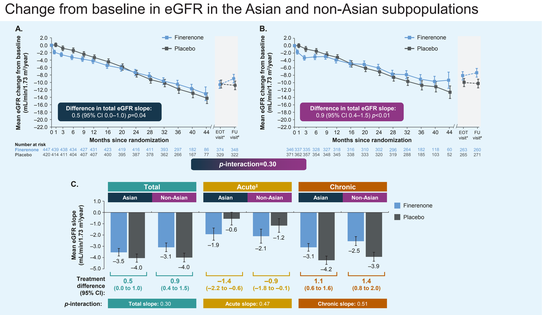
*One participant who enrolled in Israel and self-identified as Asian was excluded from the Asian subpopulation; #includes participants who reported American Indian or Alaska native race or native Hawaiian or other Pacific Islander race, did not report data on race or ethnic group (2 participants in the finerenone group and 4 participants in the placebo group) or reported more than one race or ethnic group

ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; ASCVD, atherosclerotic cardiovascular disease; BMI, body mass index; eGFR, estimated glomerular filtration rate; Q, quartile; SD, standard deviation; SGLT-2i, sodium-glucose co-transporter-2 inhibitor; UACR, urinary albumin-to-creatinine ratio

Change from baseline in eGFR

- Finerenone reduced mean eGFR decline from baseline to month 32 compared with placebo in Asian adults with nondiabetic CKD, with no significant difference in the treatment effect between Asian and non-Asian subpopulations (p-interaction=0.304)
  - The between-group difference was 0.52 mL/min/1.73 m^2/year (95% CI 0.03–1.01; p=0.039) in the Asian subpopulation (**Figure 2A**) and 0.91 mL/min/1.73 m^2/year (95% CI 0.36–1.45; p=0.001) in the non-Asian subpopulation (**Figure 2B**)
- As with the total eGFR slope, there was no significant difference in the effect of finerenone versus placebo on the acute or chronic eGFR slopes between the Asian and non-Asian subpopulations (p-interaction=0.474 and 0.515, respectively) (**Figure 2C**)

Figure 2. Change from baseline in eGFR in the Asian and non-Asian subpopulations



Mean annual rate of change in eGFR from baseline to month 44, and EOT to FU visits in the Asian (**A**) and non-Asian (**B**) subpopulations treated with finerenone or placebo. (**C**) Total, chronic, and acute eGFR slopes in the Asian versus non-Asian subpopulations treated with finerenone or placebo. The analysis was performed with a two-slope linear spline mixed-effects model that included treatment-specific fixed effects (finerenone vs placebo) for the intercept, time from randomization, time since month 3 (change point) to distinguish between the acute (i.e. from baseline to month 3) and chronic (i.e. from month 3 to discontinuation of trial regimen) eGFR slopes, and the randomization stratification factors (baseline SGLT-2i use [yes/no] and screening UACR [≤1000 mg/g vs >1000 mg/g]) and their interaction with the time components. The treatment difference in total eGFR slope was estimated at month 32

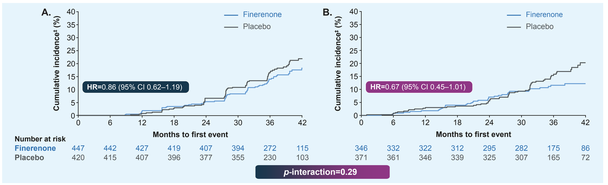
*The EOT visit took place at the end of the treatment phase, when the last participants who had undergone randomization had received finerenone or placebo for 32 months; †the FU visit occurred approximately 4 weeks after the last administration of finerenone or placebo; ‡reported in mL/min/1.73 m^2/3 months

CI, confidence interval; eGFR, estimated glomerular filtration rate; EOT, end of treatment; FU, follow-up; SGLT-2i, sodium-glucose co-transporter-2 inhibitor; UACR, urinary albumin-to-creatinine ratio

Effect of treatment on the composite kidney–CV outcome

- Finerenone lowered the risk of the composite kidney–CV outcome in the Asian and non-Asian subpopulations compared with placebo
  - The risk reductions were 14% (hazard ratio [HR]=0.86; 95% CI 0.62–1.19) in the Asian population (**Figure 3A**) and 33% (HR=0.67; 95% CI 0.45–1.01) in the non-Asian population (**Figure 3B**)
  - The effect of finerenone was not modified between Asian and non-Asian participants (p-interaction=0.294)

Figure 3. Time-to-event composite kidney–CV outcome in the Asian and non-Asian subpopulations



Cumulative incidence of the composite kidney–CV outcome (kidney failure,* ≥57% eGFR decline,† HHF, or CV death) in the Asian (**A**) and non-Asian (**B**) subpopulations treated with finerenone or placebo. Cumulative incidence calculated using an Aalen–Johansen estimator with death from any cause as a competing risk

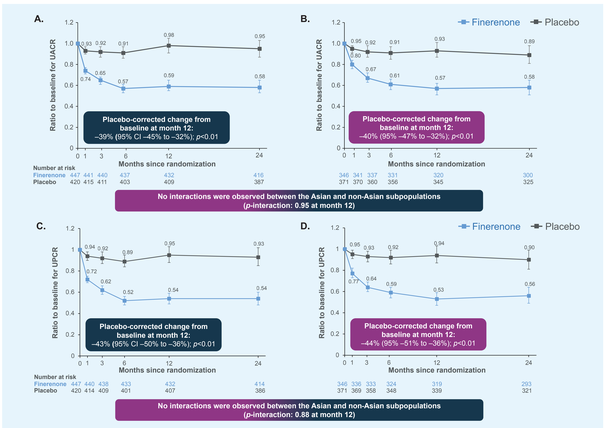
*Defined as eGFR <15 mL/min/1.73 m^2, initiation of chronic dialysis or kidney transplantation; †defined by a sustained decrease from baseline for ≥4 weeks; ‡cumulative incidence was estimated using the Aalen–Johansen estimator

CI, confidence interval; CV, cardiovascular; eGFR, estimated glomerular filtration rate; HHF, hospitalization for heart failure; HR, hazard ratio

Effect of treatment on UACR and urinary protein-to-creatinine ratio (UPCR) over time

- Over time, finerenone reduced UACR from baseline in the Asian and non-Asian participants compared with placebo
  - At month 6, finerenone was associated with a 37% reduction in UACR in the Asian subpopulation (**Figure 4A**) and a 33% reduction in the non-Asian subpopulation (**Figure 4B**) compared with placebo
- Similar results were obtained for change in UPCR over time (**Figures 4C and D**)

Figure 4. Change in UACR and UPCR over time in the Asian and non-Asian subpopulations



Change in UACR from baseline to month 24 in the Asian (**A**) and non-Asian (**B**) subpopulations treated with finerenone or placebo. Change in UPCR from baseline to month 24 in the Asian (**C**) and non-Asian (**D**) subpopulations treated with finerenone or placebo. UACR and UPCR change over time was investigated based on logarithms of the ratio to baseline at month 6 for UACR and UPCR using a mixed model with repeated measures adjusting for covariates: treatment group, visit, treatment-by-visit interaction, baseline SGLT-2i use, the interaction between SGLT-2i and visit, log-transformed baseline UACR value, and an interaction term between the log-transformed baseline value and visit

CI, confidence interval; SGLT-2i, sodium-glucose co-transporter-2 inhibitor; UACR, urinary albumin-to-creatinine ratio; UPCR, urinary protein-to-creatinine ratio

Overall safety

- Safety outcomes were generally balanced between treatment arms (**Table 2**)
- Hyperkalemia was more frequent with finerenone versus placebo in both subpopulations (Asian: 18.6% vs 13.1%; non-Asian: 15.0% vs 13.5%, respectively), however, hyperkalemia-related hospitilization and discontinuation rates were low

Table 2. TEAEs in the Asian and non-Asian subpopulations

	Asian (n=867)		Non-Asian (n=717)	
AE, n (%)	**Finerenone (n=447)**	**Placebo (n=420)**	**Finerenone (n=346)**	**Placebo (n=371)**
Any AE*	283 (63.3)	242 (57.6)	259 (74.9)	275 (74.1)
Related to study drug	98 (21.9)	71 (16.9)	77 (22.3)	62 (16.7)
Leading to permanent discontinuation	9 (2.0)	11 (2.6)	8 (2.3)	12 (3.2)
Any serious AE*	101 (22.6)	96 (22.9)	65 (18.8)	72 (19.4)
Related to study drug	4 (0.9)	4 (1.0)	5 (1.4)	2 (0.5)
Leading to permanent discontinuation	0 (0)	5 (1.2)	1 (0.3)	3 (0.8)
Leading to hospitalization	99 (22.1)	95 (22.6)	60 (17.3)	61 (16.4)
Any hyperkalemia#	83 (18.6)	55 (13.1)	52 (15.0)	50 (13.5)
Related to study drug	55 (12.3)	41 (9.8)	39 (11.3)	33 (8.9)
Leading to permanent discontinuation	6 (1.3)	0 (0)	6 (1.7)	1 (0.3)
Any serious hyperkalemia#	4 (0.9)	2 (0.5)	4 (1.2)	3 (0.8)
Leading to hospitalization	4 (0.9)	2 (0.5)	3 (0.9)	3 (0.8)
Fatal	0 (0)	0 (0)	0 (0)	0 (0)

*AEs that started or worsened after the first dose of study intervention up to 3 days after any temporary or permanent interruption of study intervention were considered as TEAEs. A serious AE could fulfill more than one reason for seriousness; #hyperkalemia included AEs with MedDRA codes 10020646 (Hyperkalaemia) and 10005725 (Blood potassium increased)

AE, adverse event; MedDRA, Medical Dictionary for Regulatory Activities; TEAE, treatment-emergent adverse event

Conclusions

- This FIND-CKD subanalysis showed that finerenone compared with placebo slowed the rate of eGFR decline, reduced the risk of composite kidney–CV outcomes and was associated with greater UACR and UPCR reductions in Asian adults with nondiabetic CKD
- Finerenone efficacy and safety were consistent in the Asian and non-Asian subpopulations
- These results support the use of finerenone to slow CKD progression and reduce adverse kidney and CV events in Asian adults with nondiabetic CKD

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