View from an Expert Bonus Content: NEPHROLOGY

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Good day. My name is Dr. Matthew Weir. I'm a professor of medicine and chief of the division of nephrology at the University of Maryland School of Medicine in Baltimore, Maryland. I'm a clinician and I specialize in the care of patients with chronic kidney disease and cardiovascular disease. I also take care of patients who have complicated hypertension and also those with kidney transplants and patients on dialysis. Thank you for rejoining us after viewing the live MLI program presented at the World Congress of Insulin Resistance, Diabetes, and Cardiovascular Disease. I'm looking forward to sharing with you some brief views and key takeaways from my standpoint as a clinical nephrologist.

I have three key takeaways to discuss and those are basically what I focus on as a clinician in the care of my patients with chronic kidney disease.

The first thing I need to do is to identify kidney disease early in its course. This is a much better strategy in order to preserve kidney function over time. The key points there are to identify people at risk using an estimated GFR and a spot urine albumin-to-creatinine ratio. Once I identify people with chronic kidney disease, I must take the time to educate them about my clinical concerns, about why we need to do what we need to do in terms of lifestyle modifications, and of course, medications.

Additionally, my focus is on preserving kidney function. The normal age-related decline in kidney function is about 1 ml per minute per year after the age of 35. The goal of kidney protective therapy is to get as close to that 1 ml per minute per year loss as we can. We've learned a lot over the years in terms of optimal therapies to slow the progression of kidney disease.

These include using renin-angiotensin system blocking drugs in the highest tolerated dose, the use of SGLT2 inhibitors, nonsteroidal mineralocorticoid receptor antagonists, and GLP-1 receptor agonists. These are four therapeutic classes of medications, which have clearly demonstrated an opportunity to delay progression of chronic kidney disease, which two, three, or four are best for an individual patient needs to be carefully individualized.

As part of this effort, one has to focus on optimal traditional risk factor modification. This includes more strict control of blood pressure, preferably below 130/80, reducing glycemic A1c to below 7%, and preferably even lower if tolerated and of course, treating cholesterol, and that is preferably having LDL cholesterol down by at least 40% from prior baseline or below an LDL number of 55 milligrams per deciliter.

My third key focus is to reduce cardiovascular events. Patients with chronic kidney disease die from cardiovascular disease and particularly congestive heart failure. My key focus here is to identify cardiovascular risk factors and treat them aggressively. It's a combination of both kidney disease progression stabilization and cardiovascular risk reduction with preferred therapies that have demonstrated success in large-scale clinical trials.

Of course, earlier identification and proper education so that patients understand quite clearly why we need to do what we're doing and to obviously work with us in ensuring success. Thank you very much for listening in today on this short view from a clinician who specializes in kidney diseases. We hope to see you again soon. Take care.