Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/tbd/37670/

Released: 09/24/2025
Valid until: 09/24/2026
Time needed to complete: 1h 02m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Optimizing Hyperkalemia Management: Clinical Implications and Risk Assessment

Announcer:
Welcome to CE on ReachMD. This activity is provided by Medtelligence and is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Butler:
This is CME on ReachMD, and I'm Dr. Javed Butler. Here with me today is Dr. James Burton. Jim, welcome to the program.

Dr. Burton:
Nice to be here.

Dr. Butler:
So as a practicing clinician, Jim, can you tell us, like when you're seeing patients with CKD and heart failure, and if you're concerned about hyperkalemia, what recommendations would you have for practicing clinicians?

Dr. Burton:
Yeah, that's a great question. And it's really good to be kind of seeing things through the lens of a kidney doctor, because after all these things are incredibly common, and they often coexist and both contribute to poor outcomes. But from a cardiorenal point of view, we know that people with heart failure and CKD, that their risk of hospitalization and need for intensive care and poor outcomes is much higher. And actually, that survival in people with heart failure and CKD is about half of that in people with heart failure alone. So it's a really vulnerable group of people.

And we know how important guideline-directed medical therapy is for people in that situation. But actually, a lot of people do not receive guideline-directed therapy, and that's a number of reasons. It might be hypotension, but one of those barriers is definitely hyperkalemia.

And it's really great to see in guidelines from—whether it's ESC or KDIGO or the UK Kidney Association, for example—that the use of novel potassium binders is becoming much more common. It's part of the strategy that we would think about for people with heart failure and CKD.

And I guess one of the recent Delphi surveys told us that hyperkalemia is predictable. We should not be down-titrating RAASi therapies in the context of hyperkalemia, because we know that once we do that, there's a risk that they will be either completely discontinued and not restarted, or remain at a suboptimal dose, and that's got really significant implications for outcomes, both in terms of mortality and hospitalization for heart failure.

But I guess the other thing to say is a lot of these risk factors are not reversible. So having heart failure, having CKD, living with diabetes, being on RAASi therapies like spironolactone, ACE inhibitors, angiotensin receptor blockers—those things aren't reversible; they're people living with their conditions and their goal-directed therapies. So potassium binders are definitely one of the strategies that we should be using and are recommended by guidelines for making sure that our vulnerable patients stay on the right therapies.

Dr. Butler:
I cannot agree with you more. But even if you're not 100% precise, you can get sort of a gut sense of who's at high risk, right? So these are the common things: increasing age, obviously our GFR goes down as we age, diabetes, chronic kidney disease, heart failure—these are sort of the things.

And then the irony is that these things don't occur in isolation, right? So they tend to occur together, and then that sort of multiplies the risk. But the issue here is that these things occurring together increases the risk of hyperkalemia, but these things occurring together increases the risk of morbidity and mortality as well. So these patients need therapy, and that's why facilitating therapy rather than stopping therapy becomes really important.

So again, if you proactively think about it and manage the patients, we have, as you mentioned, potassium binders. We can use sort of dose titration of other drugs as well, and manage their acute illnesses a little bit better, while thinking about hyperkalemia.

I think all this is manageable. We are not sort of impotent and just give up on medical therapy because of their risk. So cannot agree with you more. I really appreciate your insights. Any parting comments?

Dr. Burton:
Only to say that we just need to remember that once it's happened once, it's more likely to happen again, and the intervals between those occurrences of hyperkalemia are likely to come quicker. So just like you've said, monitoring people, keeping a close eye on those people we've got a gut feeling that this is going to be a problem, that's really important. So keep an eye on those people we've got a gut feeling about. Keep monitoring them, because if it's happened once, it's more likely to happen again.

Dr. Butler:
So that’s very interesting what you just said, right? So one interpretation of what you said is that once it happened, it's going to happen again, is to stop the treatment. But that's exactly the wrong interpretation.

The other interpretation is that if it happened once, and if it's going to happen again, means that this is a patient phenotype at higher risk of hyperkalemia, and this is exactly the phenotype we need to be treating.

Dr. Butler:
I really appreciate your time. Thank you very much, and thanks for tuning in.

Announcer:
You have been listening to CE on ReachMD. This activity is provided by Medtelligence and is part of our MinuteCE curriculum.

To receive your free CE credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.