

## NEWSLETTER 13

# Balancing Finerenone Efficacy Against Hyperkalemia

*Getting organ protection while keeping potassium safe*



Figure 13. Balancing Finerenone Efficacy Against Hyperkalemia — mechanism overview (illustrative; labels added for education).

Finerenone's biggest practical challenge is hyperkalaemia, and the 2026 evidence base helps clinicians weigh benefit against this risk. In the pooled analysis of 14,574 CKD patients, hyperkalaemia occurred more frequently with finerenone than placebo, but the absolute incidence of hyperkalaemia leading to hospitalisation was low.<sup>1</sup> The signal is real but manageable with monitoring.

Structured dosing is the first safeguard. Finerenone starts at 10–20 mg once daily and titrates to 20–40 mg, guided by eGFR and by potassium and protocol-based monitoring.<sup>3</sup> Following the trial dosing and surveillance schedule—checking potassium before initiation, after titration, and periodically thereafter—keeps most patients within a safe range.

Reassuringly, INFINITY reported that finerenone maintains a favourable safety profile across different CKD patient populations, supporting broader use rather than restriction to narrow subgroups.<sup>2</sup> Safety, like efficacy, appears consistent across the spectrum.

SGLT2 inhibitors play an unexpectedly helpful role here. Kidney and cardiovascular benefits of finerenone were consistent with or without SGLT2-inhibitor co-therapy, and SGLT2 inhibitors help preserve GFR and limit hyperkalaemia, improving tolerance to RAAS blockade and MRAs.<sup>4</sup> Co-prescribing an SGLT2 inhibitor may therefore both add efficacy and buffer potassium.

A practical monitoring rhythm makes the risk manageable in routine care: check serum potassium before starting, again after each dose increase, and periodically thereafter, adjusting or pausing therapy if levels rise.<sup>3</sup>

Because the absolute rate of hyperkalaemia serious enough to require hospitalisation was low in the pooled 14,574-patient analysis, and because INFINITY confirmed a favourable safety profile across CKD populations, the risk should inform vigilance rather than avoidance—particularly when an SGLT2 inhibitor is co-prescribed to buffer potassium.<sup>1,2</sup>

The guidelines reflect this balance. The 2026 CKM guideline positions the nonsteroidal MRA as add-on therapy when albuminuria persists on RAS inhibitors plus SGLT2 inhibitors—sequencing that lets clinicians establish the potassium-protective foundation before adding finerenone.<sup>5</sup> The 2026 ADA Standards go further, supporting simultaneous initiation of an SGLT2 inhibitor and finerenone on maximal RAS blockade, a triple regimen designed to add efficacy while managing potassium risk.<sup>6</sup> The take-home message for practice: with eGFR-guided dosing, scheduled potassium checks, and thoughtful pairing with an SGLT2 inhibitor, most CKM patients can safely obtain finerenone’s substantial kidney and cardiovascular protection.

## References

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6. Factsheet: The 2026 ADA Standards of Care — What's new?, DiabetesontheNet, Dec 2025. <https://diabetesonthenet.com/diabetes-primary-care/factsheet-2026-ada-standards/>