

NEWSLETTER 17

Expanded 2026 ADA Guidance on SGLT2i in CKD

Starting at eGFR ≥ 20 and combining with a nonsteroidal MRA



Figure 17. Expanded 2026 ADA Guidance on SGLT2i in CKD — mechanism overview (illustrative; labels added for education).

The 2026 ADA Standards of Care sharpen the role of SGLT2 inhibitors and nonsteroidal MRAs in chronic kidney disease. In addition to a RAS blocker, simultaneous initiation of an SGLT2 inhibitor and a nonsteroidal MRA (finerenone) can be considered in adults with type 2 diabetes, a UACR ≥ 100 mg/g, and an eGFR of 30–90 mL/min/1.73 m².¹ This endorses a proactive triple approach rather than sequential add-ons in higher-risk patients.

The rationale is quantitative. The combination of SGLT2 inhibitor plus finerenone on maximal ACE-inhibitor or ARB therapy produced roughly a 52% reduction in UACR—about 30% better than either drug alone, as shown in the CONFIDENCE study.² Albuminuria reduction of this magnitude is a strong surrogate for long-term kidney protection.

Threshold guidance is now more permissive. SGLT2 inhibitors can be initiated at an eGFR ≥ 20 mL/min/1.73 m² and continued through kidney failure or below that threshold once started, capturing patients previously considered “too advanced” for initiation.² The 2025 ADA Standards already recommended SGLT2 inhibitors with demonstrated benefit at eGFR ≥ 20 for CKD progression and cardiovascular event reduction, and noted that nonsteroidal MRAs do not increase acute kidney injury risk.³

Nephrology guidance is aligned. The KDIGO 2026 draft recommends SGLT2 inhibitors for adults with type 2 diabetes, CKD, and eGFR ≥ 20 (1A), continuing even if eGFR later falls below 20 unless the patient is intolerant or starts dialysis.⁴

The shift from sequential to simultaneous therapy is the conceptual heart of the update. Where earlier practice layered drugs one at a time, the 2026 Standards endorse starting an SGLT2 inhibitor and finerenone together on a background of maximal RAS blockade in higher-risk albuminuric patients—front-loading protection during the window when kidneys are deteriorating fastest.¹ The roughly 52% UACR reduction seen with the combination in CONFIDENCE, well beyond either agent alone, provides the mechanistic justification for treating aggressively and early.²

All of this dovetails with the 2026 CKM guideline, which likewise makes RAS inhibitors plus SGLT2 inhibitors first-line for CKD with type 2 diabetes or albuminuria, adding a nonsteroidal MRA or GLP-1 therapy if albuminuria persists.⁵ For clinicians, the convergence of ADA, KDIGO, and CKM guidance around the same thresholds and combinations simplifies decision-making and strengthens the mandate to treat early and combine rationally.

References

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