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Eligibility for finerenone among patients with type 2 diabetes after myocardial infarction: a single-centre registry analysis

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Introduction: Finerenone, a non-steroidal mineralocorticoid receptor antagonist (MRA), reduces cardiovascular and kidney events in type 2 diabetes with albuminuric kidney disease and is recommended on top of renin-angiotensin system (RAS) blockade and sodium-glucose cotransporter 2 inhibitors (SGLT2i). Eligibility has not been studied after myocardial infarction, where steroidal MRAs are often already prescribed.[1] We estimated how many patients with diabetes after infarction would qualify for finerenone.

Patients and Methods: This retrospective single-centre registry analysis included 180 patients with type 2 diabetes (142 known, 38 newly diagnosed) admitted with myocardial infarction between January 2024 and August 2025 who had a urinary albumin-to-creatinine ratio (UACR) measured during routine follow-up. Eligibility followed FIDELIO-DKD and FIGARO-DKD criteria: UACR ≥3 mg/mmol, admission estimated glomerular filtration rate (eGFR) ≥25 mL/min/1.73 m² and no steroidal MRA at discharge. Follow-up potassium was verified in the electronic health record.

Results: UACR was measured a median of 203 days after admission. Albuminuria was present in 42 of 180 patients (23.3%, 95% confidence interval 17.8–30.0), 41 with eGFR ≥25. Fifteen already received a steroidal MRA, 13 of them with ejection fraction ≥40% and thus potential candidates for switching. The remaining 26 (14.4% of all tested; 62% of those with albuminuria) were candidates: median age 72.5 years, 12 women, median UACR 15.6 mg/mmol (7 above 30), eGFR ≥60 in 16, 45–59 in 8, 25–44 in 2. Of these 26, 25 had been discharged on RAS blockade and 20 on an SGLT2i. Follow-up potassium was a median of 4.6 mmol/L: ≤4.8 in 20, 4.9–5.0 in 5 and 5.5 in one. Fifteen patients combined potassium ≤4.8 mmol/L with RAS blockade and an SGLT2i, leaving finerenone as the only missing element of triple cardiorenal protection.

Conclusion: After a single routine UACR measurement, one in seven patients with type 2 diabetes after myocardial infarction, and almost two thirds of those with albuminuria, met trial-based criteria for finerenone. Most already received the two other pillars of cardiorenal protection and potassium excluded only one patient, so neither renal function, nor potassium, nor polypharmacy stands between these patients and an evidence-based drug; what stands between them is a test that no cardiology guideline asks for. As the label requires persistent albuminuria, a confirmatory UACR should follow. Finerenone eligibility is a tangible, drug-specific reason to make UACR part of routine care after infarction in diabetes.

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LITERATURE

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