



## Webinar summary for healthcare professionals

# The burden and management of hyperkalemia in kidney disease

Webinar recorded on August 27, 2024



Learn about the prevalence and impact of hyperkalemia in kidney disease and latest guidelines to manage patients

## What is hyperkalemia?

Hyperkalemia (HK) is defined as a serum potassium level that is higher than 5.0 mEq/L. It is often caused by an imbalance in potassium intake and excretion.

HK often has no symptoms, but symptoms may include:

- Muscle weakness
- Heart palpitations
- ECG changes
- Paralysis
- Paresthesia

## Impact of HK on kidney disease patients

Compared to people without HK, people with HK have:

- Increased risk of mortality
- Higher rate of ER and outpatient visits
- Higher health care costs



Patients with HK and CKD often experience recurrent HK despite dietary counseling.



## Who is more likely to get HK?

HK is more common in people with chronic conditions, including:

- CKD – prevalence of HK increases with age and CKD stage
- Heart failure
- Diabetes
- Hypertension
- People taking RAASi therapies (such as an ACEi or ARB)

# HK can be a barrier to RAASi therapies for patients with CKD

RAASi therapies are a key treatment for CKD. However, 1 in 3 patients on RAASi therapy have at least 1 HK event. When patients have an HK event, providers often stop treatment with RAASi therapies, or lower the dose.

However, patients with stage 3-4 CKD who had to lower or stop their RAASi dose were twice as likely to die compared to those who stayed at their max dose. Most of these deaths were due to cardiac events.

This shows that it is important for providers to try to address HK with other methods instead of lowering or stopping RAASis.



## Action steps for providers

Follow the KDIGO 2024 guideline for the management of CKD and HK:

- ✓ Prescribe **ACEi or ARB using the highest approved dose** that is tolerated to achieve the benefits.
- ✓ Check blood pressure, serum creatinine and K+ **2-4 weeks after starting or increasing** the dose of ACEi or ARB.
  - Time depends on their current disease state and comorbidities. For example, the lower the eGFR, the worse their disease state, and the sooner you will need to see them again for repeat labs.
- ✓ **Manage HK with methods other than lowering the dose of ACEi or ARB.**
  - First try factors that can be changed:
    - ▶ Review their other medicines.
      - NSAIDs and even short courses of trimethoprim/sulfamethoxazole can affect creatinine and K+ levels.
    - ▶ Review their diet and supplements.
      - Teach them which foods they should avoid that are high in K+.
      - Ask if they use any salt substitutes, which often are high in K+.
      - Check if any of their supplements are high in K+.
  - If those changes do not work, consider medicines to lower K+:
    - ▶ K+ binders (preferred)
    - ▶ Diuretics
    - ▶ Sodium bicarbonate
- ✓ **Only reduce or stop ACEi or ARB as a last resort** if HK remains uncontrolled despite medical treatment. Review and restart ACEi or ARB at a later date, if possible.



## Resources

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You can read the 2024 KDIGO clinical practice guidelines for CKD here:

[kidney-international.org/article/S0085-2538\(23\)00766-4/fulltext](https://www.kidney-international.org/article/S0085-2538(23)00766-4/fulltext)

Send your patients to the America Kidney Fund website to learn more about hyperkalemia

at: [kidneyfund.org/beyondbananas](https://www.kidneyfund.org/beyondbananas)