Gestational Diabetes Linked to Higher CKD Risk in Black Women

Very long-term follow-up suggests a twofold increase in chronic kidney disease (CKD) risk among black women with pregnancies affected by gestational diabetes mellitus, reports a study in American Journal of Kidney Diseases.

The researchers analyzed data on 2747 women, aged 18 to 30, from the community-based “Coronary Artery Risk Development in Young Adults” (CARDIA) study. Of these, 820 women were nulliparous at baseline, had one or more pregnancies lasting 20 weeks or longer, and had available data on kidney function at up to 25 years of follow-up. Associations between gestational diabetes and CKD were assessed, with adjustment for a wide range of other factors.

Overall, 12.3% of women reported a pregnancy affected by gestational diabetes. At a mean follow-up of 20.8 years, 12.8% of women had developed CKD. Of 105 cases of CKD, 98 were defined by albuminuria only (urine albumin-to-creatinine ratio of 25 mg/g or higher).

Gestational diabetes was associated with an increased risk of CKD only among black women: adjusted hazard ratio (HR) 1.96 (95% confidence interval 1.04 to 3.67). For white women, the association was nonsignificant, with an HR of 0.65 (95% confidence interval 0.32 to 1.30). Among black women, CKD developed in 31.0% of those with gestational diabetes versus 15.6% of those without gestational diabetes. Among white women, the figures were 6.8% versus 10.0%, respectively.

The study was designed to determine whether gestational diabetes is associated with increased risk of CKD, after controlling for prepregnancy factors associated with both conditions. The results show a significant long-term increase in CKD, defined by albuminuria, among black but not white women with a history of gestational diabetes.


VELTASSA® (patiromer) for Oral Suspension

Brief Summary of Prescribing Information. Please see Full Prescribing Information for complete product information.

INDICATIONS AND USAGE

VELTASSA is indicated for the treatment of hyperkalemia.

Limitation of Use: VELTASSA should not be used as an emergency treatment for life-threatening hyperkalemia because of its delayed onset of action.

CONTRAINDICATIONS

VELTASSA is contraindicated in patients with a history of a hypersensitivity reaction to VELTASSA or any of its components [see Adverse Reactions].

WARNINGS AND PRECAUTIONS

Worsening of Gastrointestinal Motility

Avoid use of VELTASSA in patients with severe constipation, bowel obstruction or impaction, including abnormal post-operative bowel motility disorders, because VELTASSA may be ineffective and may worsen gastrointestinal conditions. Patients with a history of bowel obstruction or major gastrointestinal surgery, severe gastrointestinal disorders, or swallowing disorders were not included in the clinical studies.

Hypomagnesemia

VELTASSA binds to magnesium in the colon, which can lead to hypomagnesemia. In clinical studies, hypomagnesemia was reported as an adverse reaction in 5.3% of patients treated with VELTASSA [see Adverse Reactions]. Monitor serum magnesium. Consider magnesium supplementation in patients who develop low serum magnesium levels on VELTASSA.

ADVERSE REACTIONS

The following adverse reaction is discussed in greater detail elsewhere in the label:

• Hypomagnesemia [see Warnings and Precautions]

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of VELTASSA cannot be directly compared to rates in the clinical trials of other drugs and may not reflect the rates observed in practice.

In the safety and efficacy clinical trials, 666 adult patients received at least one dose of VELTASSA, including 219 exposed for at least 6 months and 149 exposed for at least one year. Table 1 provides a summary of the most common adverse reactions (occurring in > 2% of patients) in patients treated with VELTASSA in these clinical trials. Most adverse reactions were mild to moderate. Constipation generally resolved during the course of treatment.

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>Patients treated with VELTASSA (N=666)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>7.2%</td>
</tr>
<tr>
<td>Hypomagnesemia</td>
<td>5.3%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>4.8%</td>
</tr>
<tr>
<td>Nausea</td>
<td>2.3%</td>
</tr>
<tr>
<td>Abdominal discomfort</td>
<td>2.0%</td>
</tr>
<tr>
<td>Flatulence</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

During the clinical studies, the most commonly reported adverse reactions leading to discontinuation of VELTASSA were gastrointestinal adverse reactions (2.7%), including vomiting (0.8%), diarrhea (0.8%), constipation (0.5%) and flatulence (0.5%). Mild to moderate hypersensitivity reactions were reported in 0.3% of patients treated with VELTASSA in clinical trials. Reactions have included edema of the lips.

Laboratory Abnormalities

Approximately 4.7% of patients in clinical trials developed hypomagnesemia with a serum magnesium value < 1.3 mg/dL. Approximately 9% of patients in clinical trials developed hypomagnesemia with a serum magnesium value < 1.4 mg/dL.

DRUG INTERACTIONS

In clinical studies, VELTASSA decreased systemic exposure of some coadministered oral medications. Binding of VELTASSA to other oral medications could cause decreased gastrointestinal absorption and loss of efficacy when taken close to the time VELTASSA is administered. Administer other oral medications at least 3 hours before or 3 hours after VELTASSA.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

VELTASSA is not absorbed systemically following oral administration and maternal use is not expected to result in fetal risk.

Lactation

Risk Summary

VELTASSA is not absorbed systemically by the mother, so breastfeeding is not expected to result in risk to the infant.

Pediatric Use

Safety and efficacy in pediatric patients have not been established.

Geriatric Use

Of the 666 patients treated with VELTASSA in clinical studies, 58.9% were age 65 and over, and 19.8% were age 75 and over. No overall differences in effectiveness were observed between these patients and younger patients. Patients age 65 and older reported more gastrointestinal adverse reactions than younger patients.

Renal Impairment

Of the 666 patients treated with VELTASSA in clinical studies, 93% had chronic kidney disease (CKD). No special dosing adjustments are needed for patients with renal impairment.

OVERDOSAGE

Doses of VELTASSA in excess of 50-4 grams per day have not been tested. Excessive doses of VELTASSA may result in hypokalemia. Restore serum potassium if hypokalemia occurs.

PATIENT COUNSELING INFORMATION

Drug Interactions

Advise patients who are taking other oral medication to separate the dosing of VELTASSA by at least 3 hours (before or after) [see Drug Interactions].

Dosing Recommendations

Instruct patients to take VELTASSA as directed with food and adhere to their prescribed diet. Inform patients that VELTASSA should not be heated (e.g., microwaved) or added to heated foods or liquids and should not be taken in its dry form.

Manufactured by:

Relypsa, Inc.

Redwood City, CA 94063

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Early Conversion to Belatacept: A Case-Control Study

In kidney transplant recipients with low kidney function, early conversion from tacrolimus- to belatacept-based immunosuppression leads to a small but significant increase in estimated glomerular filtration rate (eGFR), reports a study in Transplantation.

The retrospective study included two groups of 30 matched transplant recipients with low but stable eGFR; typically less than 40 mL/min/m². From 2012 to 2016, the study center had a protocol to convert patients with low kidney function to low 1 month posttransplant from tacrolimus to belatacept. Cases were matched on a wide range of variables to controls maintained on calcineurin inhibitors (CNIs).

Mean change in GFR during the first 4 months after conversion was 11 mL/min/m² in patients converted to belatacept versus 4.8 mL/min/m² in the control cohort. This was despite a 16.7% rate of acute rejection in the conversion group, compared to zero in the control group. The improvement in kidney function was still present after 1 year. The two groups had similar allograft and patient survival at 2 years.

Previous reports from the BENEFIT trial showed that in kidney function in patients started on belatacept-based immunosuppression after kidney transplantation, compared to CNIs. Less is known about the effects of converting from CNI- to belatacept-based therapy.

This retrospective study reports a “modest increase” in kidney function with early conversion from tacrolimus to belatacept in kidney recipients with low but stable eGFR [Elhamahmi DA, et al. Early conversion to belatacept in kidney transplant recipient with low glomerular filtration rate [Transplantation 2017; DOI: 10.1097/ TD000000000001985].