The treatment of type 2 diabetes in the presence of renal impairment: what we should know about newer therapies

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Abstract: Worldwide, an estimated 200 million people have chronic kidney disease (CKD), the most common causes of which include hypertension, arteriosclerosis, and diabetes. Importantly, ~40% of patients with diabetes develop CKD, yet evidence from major multicenter randomized controlled trials shows that intensive blood glucose control through pharmacological intervention can reduce the incidence and progression of CKD. Standard therapies for the treatment of type 2 diabetes include metformin, sulfonylureas, meglitinides, thiazolidinediones, and insulin. While these drugs have an important role in the management of type 2 diabetes, only the thiazolidinedione pioglitazone can be used across the spectrum of CKD (stages 2–5) and without dose adjustment; there are contraindications and dose adjustments required for the remaining standard therapies. Newer therapies, particularly dipeptidyl peptidase-IV inhibitors, glucagon-like peptide-1 receptor agonists, and sodium-glucose cotransporter-2 inhibitors, are increasingly being used in the treatment of type 2 diabetes; however, a major consideration is whether these newer therapies can also be used safely and effectively across the spectrum of renal impairment. Notably, reductions in albuminuria, a marker of CKD, are observed with many of the drug classes. Dipeptidyl peptidase-IV inhibitors can be used in all stages of renal impairment, with appropriate dose reduction, with the exception of linagliptin, which can be used without dose adjustment. No dose adjustment is required for liraglutide, albiglutide, and dulaglutide in CKD stages 2 and 3, although all glucagon-like peptide-1 receptor agonists are currently contraindicated in stages 4 and 5 CKD. At stage 3 CKD or greater, the sodium-glucose cotransporter-2 inhibitors ( dapagliflozin, canagliflozin, and empagliflozin) either require dose adjustment or are contraindicated. Ongoing trials, such as CARMELINA, MARLINA, CREDENCE, and CANVAS-R, will help determine the position of these new therapy classes and if they have renoprotective effects in patients with CKD.

Keywords: DPP-IV inhibitor, GLP-1RA, SGLT-2 inhibitor, PK, chronic kidney disease, renal impairment

Introduction

Chronic kidney disease (CKD) can adversely affect the pharmacokinetics (PK) or pharmacodynamics (PD) of some therapies. Thus, in order for clinicians to make informed choices, it is important to understand how: 1) the use of glucose-lowering therapies is affected by renal impairment; 2) treatment regimens may need to be modified and how these treatments may impact on CKD outcomes; and 3) the importance of safety across the spectrum of CKD.

Worldwide, an estimated 200 million people have CKD, a long-term condition that may lead to renal failure and, if left untreated, to premature death. CKD is characterized...
**Table 1** National Kidney Foundation criteria for CKD

<table>
<thead>
<tr>
<th>Criteria (either present for ≥3 months)</th>
<th>Abnormalities of kidney structure or function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Markers of kidney damage (one or more)</td>
<td>Albuminuria (AER ≥ 30 mg/24 h; ACR ≥ 30 mg/g; ≥ 3 mg/mmol)</td>
</tr>
<tr>
<td></td>
<td>Urine sediment abnormalities</td>
</tr>
<tr>
<td></td>
<td>Electrolyte and other abnormalities due to tubular disorders</td>
</tr>
<tr>
<td></td>
<td>Abnormalities detected by histology</td>
</tr>
<tr>
<td></td>
<td>Structural abnormalities detected by imaging</td>
</tr>
<tr>
<td>Decreased GFR</td>
<td>GFR &lt; 60 mL/min/1.73 m² (GFR categories CKD 3a–5)</td>
</tr>
</tbody>
</table>

**Notes:** Reprinted from Kidney Int, Suppl, 3(1). Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group, KDIGO 2012 clinical practice guideline for the evaluation and management of chronic kidney disease, 1–163, Copyright (2013), with permission from Elsevier.

**Abbreviations:** ACR, albumin-to-creatinine ratio; AER, albumin excretion rate; CKD, chronic kidney disease; GFR, glomerular filtration rate.

by the presence of kidney damage, indicated by albuminuria and/or a gradual loss of kidney function (estimated glomerular filtration rate [eGFR]) over time. Common causes of CKD include hypertension, atherosclerosis, and diabetes. Furthermore, CKD is associated with an elevated risk of death from cardiovascular (CV) disease. Kidney Disease: Improving Global Outcomes criteria and associated CKD stages are summarized in Tables 1 and 2, respectively.

Approximately 40% of patients with diagnosed or undiagnosed diabetes have CKD and, in the absence of monitoring for and effective treatment of renal function, CKD can develop insidiously. Pathological changes in the kidney include increased glomerular basement membrane thickness, formation of microaneurysms, and mesangial nodules. The current estimates show a global prevalence of 415 million adults with diabetes, with type 2 diabetes (T2D) accounting for ~90% of these patients; CKD in diabetes is, thus, a significant health problem. Atherosclerosis is also an associated condition, leading to narrowing of arterial walls and subsequent high blood pressure. Diabetic nephropathy is generally, but not always, preceded by albuminuria, defined as proteinuria of >500 mg/day. In fact, there is evidence that intensively improving blood glucose control through pharmacological intervention can reduce the incidence and progression of CKD in people with diabetes. The UK Prospective Diabetes Study found a reduced risk of progressive kidney disease with intensive glycemic control, apparent from a 34% reduction in albuminuria, 67% reduction in the proportion of patients who had a twofold increase in plasma creatinine, and 74% reduction in the proportion of patients who had doubling of plasma urea. In addition, the Action in Diabetes and Vascular Disease: Preterax and DiaMict MR Controlled Evaluation trial determined that intensive glucose control significantly reduced the risk of progression to stage 5 CKD by 65%, microalbuminuria by 9%, and macroalbuminuria by 30%. In the Steno-2 study, patients with T2D and microalbuminuria receiving intensive therapy (compared with conventional therapy) had a significantly lower risk of nephropathy (hazard ratio: 0.39, 95% confidence interval [CI]: 0.17–0.87; *P* < 0.003).

A recent meta-analysis demonstrated that combination therapies are effective in improving glycemic control, with some combinations of metformin and newer drug classes (specifically, dipeptidyl peptidase-IV [DPP-IV] inhibitors, glucagon-like peptide-1 receptor agonists [GLP-1RAs], and sodium-glucose cotransporter-2 [SGLT-2] inhibitors) providing glycemic control without increasing the risk of hypoglycemia or weight gain. Indeed, many current treatment guidelines now advocate the use of these newer therapies in multiple stepwise combinations.

As previous reviews have already investigated the impact of conventional glucose-lowering therapies on CKD, this review will primarily focus on the newer therapies (DPP-IV inhibitors, GLP-1RAs, and SGLT-2 inhibitors), mechanisms by which CKD affects the use of T2D therapies, place of these therapies in CKD treatment, and their potential renoprotective effects.

### Table 2 Staging of CKD

<table>
<thead>
<tr>
<th>GFR grade</th>
<th>GFR (mL/min/1.73 m²)</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>≥ 90</td>
<td>Normal or high*</td>
</tr>
<tr>
<td>2</td>
<td>60–89</td>
<td>Mildly decreased*</td>
</tr>
<tr>
<td>3a</td>
<td>45–59</td>
<td>Mildly to moderately decreased*</td>
</tr>
<tr>
<td>3b</td>
<td>30–44</td>
<td>Moderately to severely decreased</td>
</tr>
<tr>
<td>4</td>
<td>15–29</td>
<td>Severely decreased</td>
</tr>
<tr>
<td>5</td>
<td>&lt; 15</td>
<td>Kidney failure</td>
</tr>
</tbody>
</table>

**Notes:** *In the absence of evidence of kidney damage, neither GFR grade 1 nor grade 2 fulfills the criteria for CKD.* Relative to young adult level. Reprinted from Kidney Int Suppl, 3(1). Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group, KDIGO 2012 clinical practice guideline for the evaluation and management of chronic kidney disease, 1–163, Copyright (2013), with permission from Elsevier.

**Abbreviations:** CKD, chronic kidney disease; GFR, glomerular filtration rate.

### T2D therapies and CKD

#### Conventional glucose-lowering therapies

Conventional glucose-lowering therapies include metformin, sulfonylureas, thiazolidinediones, meglitinides, and insulin.

Apart from pioglitazone, a thiazolidinedione, other conventional therapies must be reduced or withdrawn as eGFR declines due to increased risk of lactic acidosis (in the case of metformin) and hypoglycemia (in the case of sulfonylureas, meglitinides [such as repaglinide], and insulin). Their use in CKD is described below and summarized in Table 3.
Metformin

Metformin may be used without dose adjustment in patients with stage 2 CKD. With dose adjustment, metformin may be used in patients with stage 3a CKD, but only in the absence of other conditions, such as liver dysfunction, CV disease, and renal disease, which may increase the risk of lactic acidosis. Renal function must be closely monitored every 3–6 months and, if eGFR falls to <45 mL/min/1.73 m², metformin administration must be stopped. Current UK National Institute for Health and Care Excellence guidelines suggest stopping if eGFR falls to <30 mL/min/1.73 m². Clinical data on the risk of lactic acidosis in metformin-treated patients with CKD are currently limited.

Sulfonylureas

Patients with CKD who are treated with glipizide, glibenclamide, gliclazide, and glimepiride require careful monitoring. Moreover, these sulfonylureas are contraindicated in patients with stage 4 CKD. The PK and/or PD of glipizide may be altered in patients with impaired renal function; initial and maintenance dosing should, therefore, be conservative to avoid hypoglycemic episodes. Glibenclamide should be used cautiously in patients with stages 2 and 3 CKD; however, in long-term clinical trials, patients with renal impairment have been treated adequately at reduced doses with frequent monitoring. Likewise, in long-term clinical trials, patients with renal impairment have also been treated adequately using gliclazide at reduced doses with frequent monitoring.

In the case of glimepiride, in patients with low creatinine clearance (CrCl), there is a trend for glimepiride clearance to elevate and serum concentrations to diminish.

Meglitinides

The meglitinides, such as repaglinide, are short-acting. Patients with CKD ranging from stages 3b to 5 require careful management. Repaglinide is mostly metabolized by the liver and, with dose adjustment, may be used in patients with CKD. In a clinical trial, after 5 days of treatment with repaglinide, there was a twofold increase in exposure (area under the curve [AUC]) and half-life in patients with stage 4 CKD compared with individuals with normal renal function.

Thiazolidinediones

Of the thiazolidinedione family, only pioglitazone is generally available due to safety concerns with other agents in this class. No dose adjustment is required with impaired renal function (stages 2–5 CKD), as pioglitazone is metabolized mainly by the liver. No information is available for patients undergoing dialysis; therefore, pioglitazone should not be used in this setting. Plasma concentrations of pioglitazone and its metabolites in patients with CKD are lower than those in patients with normal renal function and may take longer to elevate and serum concentrations to diminish.

Table 3 The use of conventional glucose-lowering therapies in chronic kidney disease (based on European Union label)

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Licensed dose</th>
<th>eGFR (mL/min/1.73 m²) (associated stage)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>60–89 (stage 2)</td>
</tr>
<tr>
<td>Metformin</td>
<td>500 mg or 850 mg bid or tid</td>
<td>✓</td>
</tr>
<tr>
<td>Glipizide</td>
<td>2.5–20 mg daily</td>
<td>-</td>
</tr>
<tr>
<td>Glibenclamide</td>
<td>2.5–15 mg daily</td>
<td>-</td>
</tr>
<tr>
<td>Gliclazide</td>
<td>40–320 mg daily</td>
<td>-</td>
</tr>
<tr>
<td>Glimepiride</td>
<td>1–6 mg daily</td>
<td>-</td>
</tr>
<tr>
<td>Repaglinide</td>
<td>0.5–16 mg daily</td>
<td>✓</td>
</tr>
<tr>
<td>Pioglitazone</td>
<td>15–45 mg od</td>
<td>✓</td>
</tr>
<tr>
<td>Acarbose</td>
<td>50 mg tid</td>
<td>✓</td>
</tr>
<tr>
<td>NPH insulin</td>
<td>According to the requirement of the patient</td>
<td>✓</td>
</tr>
<tr>
<td>Insulin glargine</td>
<td>According to the requirement of the patient</td>
<td>✓</td>
</tr>
<tr>
<td>Insulin detemir</td>
<td>According to the requirement of the patient</td>
<td>✓</td>
</tr>
<tr>
<td>Insulin degludec</td>
<td>According to the requirement of the patient</td>
<td>✓</td>
</tr>
<tr>
<td>Insulin lispro</td>
<td>According to the requirement of the patient</td>
<td>✓</td>
</tr>
<tr>
<td>Insulin glulisine</td>
<td>According to the requirement of the patient</td>
<td>✓</td>
</tr>
<tr>
<td>Insulin aspart</td>
<td>According to the requirement of the patient</td>
<td>✓</td>
</tr>
</tbody>
</table>

Notes: ✓ Indicated and no dose adjustment required. “-” Indication may be variable/consider dose reduction, frequent monitoring and relevant health status. *Contraindicated. Second-generation SU. Third-generation SU. Patients with severely impaired renal function (CrCl 20–39 mL/min) showed a significant twofold increase in AUC and t½ as compared with individuals with normal renal function. No dose adjustment required if eGFR ≥4 mL/min. Avoided if eGFR ≤25 mL/min/1.73 m². Intermediate-acting insulin. Long-acting insulin. Fast-acting insulin.

Abbreviations: AUC, area underneath the curve; bid, twice daily; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate; NPH, neutral protamine Hagedorn; NS, not stated; od, once daily; SU, sulfonylurea; t½, half-life; tid, three times daily.
observed in individuals with normal renal function, but the parent compound shows comparable apparent clearance.\textsuperscript{20} Edema occurs in $\sim$5\% of patients treated with pioglitazone in monotherapy or combination therapy.\textsuperscript{40} Although there have been concerns over CV risk,\textsuperscript{41} a recent study showed that pioglitazone was not associated with any increase in CV adverse events (AEs).\textsuperscript{41}

**Alpha-glucosidase inhibitors**

The alpha-glucosidase inhibitor acarbose has gastrointestinal side effects associated with its use, including flatulence, soft stools, and abdominal discomfort.\textsuperscript{34,42} Acarbose is excreted unaltered by the renal system and should not be initiated in patients with stage 4 CKD.\textsuperscript{44}

**Amylin analogs**

Amylin analogs, such as pramlintide, are commonly used in the US. Pramlintide has limited side effects but a small proportion of patients may have intolerable nausea despite receiving the lowest doses.\textsuperscript{43} The dosing requirements for pramlintide are not altered in patients with stages 2–4 CKD.\textsuperscript{43} Pramlintide has not been studied in patients with stage 5 CKD.\textsuperscript{43}

**Dopamine agonists**

Dopamine agonists, such as bromocriptine, are commonly used in the US. Common side effects of bromocriptine include nausea, asthenia, constipation, dizziness, and rhinitis.\textsuperscript{44} No PK studies have been conducted in patients with renal impairment.\textsuperscript{45} Although the kidney is a minor pathway for elimination of bromocriptine, careful monitoring should be undertaken in patients with renal impairment.\textsuperscript{45}

**Insulin**

Classes of insulin include intermediate-acting (neutral protamine Hagedorn insulin, indicated for basal coverage), long-acting (glargine 100 units/mL\textsuperscript{29} and 300 units/mL [U300],\textsuperscript{16} detemir\textsuperscript{29} and degludec\textsuperscript{30} indicated for basal coverage), and fast-acting (lispro,\textsuperscript{47} glulisine,\textsuperscript{48} and aspart,\textsuperscript{49} indicated for prandial coverage). CKD may reduce insulin requirements dramatically and increase the risk for hypoglycemia in patients.\textsuperscript{50} Insulin dose, therefore, needs to be adjusted on an individual basis.

In patients with CKD, glargine requirements may be diminished because of reduced insulin metabolism;\textsuperscript{28,46,16} the high concentration of insulin (U300) results in different PK and PD profiles, but both concentrations have been shown to be safe in patients with renal failure.\textsuperscript{46,51,52} In a clinical study, the PK of detemir did not significantly differ in patients with stages 3–4 CKD compared with healthy individuals.\textsuperscript{53} Likewise, in one clinical study, renal impairment did not have a significant effect on maximum concentration ($C_{\text{max}}$), apparent clearance, or AUC$_{0–120\text{h}}$ of single-dose degludec.\textsuperscript{30,54}

The glucodynamic response to insulin lispro is not affected by renal impairment.\textsuperscript{31,47} Glulisine requirements may be reduced in the presence of renal impairment.\textsuperscript{52} In patients with type 1 diabetes, renal impairment (stages 2–5 CKD) did not affect the PK of aspart in a clinically significant manner.\textsuperscript{33,55}

**Newer therapies**

DPP-IV inhibitors, GLP-1RAs, and SGLT-2 inhibitors are the most recent classes of agents licensed for use in T2D in Europe. The use of newer therapies in CKD is described below and summarized in Table 4.

**DPP-IV inhibitors**

DPP-IV inhibitors, such as sitagliptin, vildagliptin, saxagliptin, alogliptin and linagliptin, reduce the physiological breakdown of native GLP-1, which increases the secretion of insulin and promotes satiety, effectively decreasing blood glucose levels.\textsuperscript{70} A meta-analysis has shown that DPP-IV inhibitors are effective in lowering glycated hemoglobin (HbA$_1c$) in patients with T2D and stages 3–4 CKD ($-0.52\%$, 95\% CI: $-0.64$ to $-0.39$).\textsuperscript{71} Despite associations with AEs that include nasopharyngeal symptoms, headaches, angioedema,\textsuperscript{72,73} and pancreatitis,\textsuperscript{72} meta-analyses showed low prevalence of such AEs.\textsuperscript{74,75}

DPP-IV inhibitors are metabolized and eliminated in a number of different ways. Their mode of action (MOA) and elimination, as well as PK and safety, are described in Table 5.

**Sitagliptin**

Sitagliptin undergoes limited hepatic metabolism; ~80\% of the dose is excreted renally, and there is a low, reversible protein binding in the plasma (38\%).\textsuperscript{76} The TECOS study showed that sitagliptin was noninferior to placebo for the primary composite CV outcome of CV death, nonfatal myocardial infarction, nonfatal stroke, or hospitalization for unstable angina (hazard ratio 0.98, 95\% CI: 0.88–1.09; $P<0.001$).\textsuperscript{83} In addition, no significant differences between the placebo and sitagliptin group in incidences of pancreatic cancer ($P=0.32$), acute pancreatitis ($P=0.07$), or hospitalization for heart failure ($P=0.98$) were reported.\textsuperscript{83} In T2D patients, sitagliptin has also been
shown to reduce significantly urinary albumin excretion \((P<0.0001)\).\textsuperscript{84}

One PK study in patients without T2D showed that, compared with healthy controls, plasma sitagliptin AUC levels in patients with stages 2–5 CKD were increased by factors of 1.6–4.5.\textsuperscript{77} \(C_{\text{max}}\) was moderately increased, and concentration at 24 hours increased as severity of CKD increased. Time to \(C_{\text{max}}\) was significantly increased in patients with stage 5 CKD, and the half-life increased with increasing severity of CKD. For patients with stages 2–4 CKD, clearance rates were 0.18–0.71 mL/min.\textsuperscript{77}

In treatment, patients with stage 2 CKD and stage 3 CKD (if eGFR is \(\geq 50\) mL/min) require no dose adjustment. For stage 3 CKD and an eGFR of \(<50\) mL/min, the sitagliptin dose should be reduced to 50 mg once daily (od). For patients with stages 4–5 CKD, including those undertaking hemodialysis or peritoneal dialysis, the dose should be decreased to 25 mg od. Treatment can be administered regardless of dialysis time.\textsuperscript{56}

**Vildagliptin**

Vildagliptin is metabolized via four metabolic pathways before excretion.\textsuperscript{85} Overall, 77% of the vildagliptin dose is excreted renally (22% as parent, 55% as primary metabolite). In the plasma, vildagliptin shows low (10%), reversible protein binding.\textsuperscript{76} In patients in early stages of nephropathy, vildagliptin significantly decreased albumin concentrations.\textsuperscript{86}

In a PK study, patients with stages 2–5 CKD, systemic exposure to vildagliptin was increased (\(C_{\text{max}}\): 8%–66%; AUC extrapolated to infinity: 32%–134%) compared with healthy individuals.\textsuperscript{78} Changes in exposure to vildagliptin showed no relationship with severity of CKD. No safety data were reported.\textsuperscript{79} A later study showed that the mean AUC of vildagliptin after 14 days in patients with stages 2–4 CKD increased by 40%–100%. Vildagliptin \(C_{\text{max}}\) increased by 32%–37%.\textsuperscript{79} Vildagliptin was generally safe and well tolerated in both healthy individuals and patients with different stages of CKD.

In treatment, no dose adjustment of vildagliptin is required in patients with stage 2 CKD. In patients with stages 3–5 CKD, for safety, the recommended dose is 50 mg od.\textsuperscript{57}

**Saxagliptin**

Saxagliptin is metabolized in the liver, producing an active metabolite. It is eliminated via the kidney (12%–29% as parent, 21%–52% as metabolite).\textsuperscript{70} In the plasma, saxagliptin shows negligible protein binding.\textsuperscript{76}

The Saxagliptin Assessment of Vascular Outcomes Recorded in Patients with Diabetes Mellitus–Thrombolysis in Myocardial Infarction 53 (SAVOR-TIMI 53) trial confirmed that the CV safety of saxagliptin met US Food and

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### Table 4 Newer glucose-lowering therapies and data regarding their use in CKD (based on European Union label)

<table>
<thead>
<tr>
<th>Drug class</th>
<th>eGFR (mL/min/1.73 m²) (associated stage)</th>
<th>Therapy</th>
<th>Licensed dose</th>
<th>60–89 (stage 2)</th>
<th>45–59 (stage 3a)</th>
<th>30–44 (stage 3b)</th>
<th>15–29 (stage 4)</th>
<th>&lt;15 (stage 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPP-IV inhibitors</td>
<td></td>
<td>Sitagliptin\textsuperscript{56}</td>
<td>25–100 mg daily</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vildagliptin\textsuperscript{57}</td>
<td>50–100 mg daily</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Saxagliptin\textsuperscript{58}</td>
<td>2.5–5 mg daily</td>
<td>✓</td>
<td>–</td>
<td>✓</td>
<td></td>
<td>✓\textsuperscript{3}</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Linagliptin\textsuperscript{59}</td>
<td>5 mg daily</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alogliptin\textsuperscript{60}</td>
<td>6.25–25 mg daily</td>
<td>✓</td>
<td>–</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>GLP-1RAs</td>
<td></td>
<td>Exenatide bid\textsuperscript{61}</td>
<td>5–10 μg sc injection bid</td>
<td>✓</td>
<td>✓\textsuperscript{5}</td>
<td>–</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exenatide ow\textsuperscript{62}</td>
<td>2 mg sc injection ow</td>
<td>✓</td>
<td>✓\textsuperscript{5}</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lixisenatide\textsuperscript{63}</td>
<td>10–20 μg sc injection od</td>
<td>✓</td>
<td>✓\textsuperscript{5,c}</td>
<td>–</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liraglutide\textsuperscript{64}</td>
<td>0.6–1.8 mg sc injection od</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Albglutide\textsuperscript{65}</td>
<td>30–50 mg sc injection ow</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dulaglutide\textsuperscript{66}</td>
<td>0.75–1.5 mg sc injection ow</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>SGLT-2 inhibitors</td>
<td></td>
<td>Dapagliflozin\textsuperscript{67}</td>
<td>5–10 mg od</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Canagliflozin\textsuperscript{68}</td>
<td>100–300 mg od</td>
<td>✓\textsuperscript{a}</td>
<td>–d\textsuperscript{b}</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Empagliflozin\textsuperscript{69}</td>
<td>10–25 mg od</td>
<td>✓</td>
<td>–\textsuperscript{e}</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

**Notes:** ✓ Indicated and no dose adjustment required. –✓ Indication may be variable/consider dose reduction, frequent monitoring and relevant health status. × Contraindicated. No dose adjustment required if eGFR is \(>50\) mL/min. Contraindicated if GFR \(<50\) mL/min. In patients tolerating canagliflozin whose eGFR falls persistently below 60 mL/min/1.73 m² or CrCl 60 mL/min, the canagliflozin dose should be altered to or maintained at 100 mg od. In patients tolerating empagliflozin whose eGFR falls persistently below 60 mL/min/1.73 m² or CrCl below 60 mL/min, the dose should be altered to or managed at 10 mg od.

**Abbreviations:** bid, twice daily; CKD, chronic kidney disease; CrCl, creatinine clearance; DPP-IV, dipeptidyl peptidase-IV; eGFR, estimated glomerular filtration rate; GLP-1 RA, glucagon-like peptide-1 receptor agonist; GFR, glomerular filtration rate; od, once daily; ow, once weekly; sc, subcutaneous; SGLT-2, sodium-glucose cotransporter-2.
### Table 5 DPP-IV inhibitors: modes of action, modes of excretion, and studies investigating PK

<table>
<thead>
<tr>
<th>Licensed drug</th>
<th>Mode of action</th>
<th>Mode of excretion</th>
<th>Study design</th>
<th>PK findings</th>
<th>Safety</th>
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<tr>
<td>Sitagliptin</td>
<td>Blocks DPP-IV, which degrades incretins&lt;sup&gt;70&lt;/sup&gt;</td>
<td>80% excreted renally&lt;sup&gt;76&lt;/sup&gt;</td>
<td>Bergman et al (2007)&lt;sup&gt;77&lt;/sup&gt;</td>
<td>Compared with healthy individuals, AUC levels in patients with stages 2, 3, 4, and 5 CKD were elevated by factors of 1.6, 2.3, 3.8, and 4.5, respectively</td>
<td>Safety data not described</td>
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<td></td>
<td>Blocks GLP-1-mediated insulin secretion&lt;sup&gt;79&lt;/sup&gt;</td>
<td>Clearance: 350 mL/min&lt;sup&gt;26&lt;/sup&gt;</td>
<td>Open-label, two-part study</td>
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<td>Single 50 mg dose</td>
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<td>n=30 (normal RF, CKD 2, CKD 3, CKD 4, and CKD 5)&lt;sup&gt;6&lt;/sup&gt;</td>
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<td>Healthy individuals (n=145) from eleven other studies were included as a historical control group</td>
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<tr>
<td>Vildagliptin</td>
<td>Blocks DPP-IV, which degrades incretins&lt;sup&gt;70&lt;/sup&gt;</td>
<td>77% of the vildagliptin dose is excreted renally&lt;sup&gt;76&lt;/sup&gt;</td>
<td>He et al (2007)&lt;sup&gt;79&lt;/sup&gt;</td>
<td>Compared with individuals with normal RF, exposure to vildagliptin was increased in patients with stages 2, 3, 4, and 5 CKD (C&lt;sub&gt;max&lt;/sub&gt;: 8%–66%; AUC&lt;sub&gt;0–∞&lt;/sub&gt;: 32%–134%), in comparison with healthy individuals</td>
<td>Safety data not described</td>
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<td></td>
<td>Blocks GLP-1-mediated insulin secretion&lt;sup&gt;79&lt;/sup&gt;</td>
<td>Clearance: 13 L/h&lt;sup&gt;77&lt;/sup&gt;</td>
<td>Design not specified</td>
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<td>Single 100 mg dose</td>
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<td>n=30 (normal RF, CKD 2, CKD 3, CKD 4, and CKD 5)&lt;sup&gt;6&lt;/sup&gt;</td>
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<tr>
<td>Saxagliptin</td>
<td>Blocks DPP-IV, which degrades incretins&lt;sup&gt;70&lt;/sup&gt;</td>
<td>Renal route (12%–29% as parent, 21%–52% as metabolite)&lt;sup&gt;76&lt;/sup&gt;</td>
<td>Boulton et al (2011)&lt;sup&gt;80&lt;/sup&gt;</td>
<td>Compared with individuals with normal RF, saxagliptin AUC&lt;sub&gt;0–∞&lt;/sub&gt; values were 16%, 41%, and 108% higher in CKD patients with stages 2, 3, and 4, respectively</td>
<td>Safety data not described</td>
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<tr>
<td></td>
<td>Blocks GLP-1-mediated insulin secretion&lt;sup&gt;79&lt;/sup&gt;</td>
<td>Clearance: ~230 mL/min&lt;sup&gt;18&lt;/sup&gt;</td>
<td>Open-label, parallel-group study</td>
<td>As CrCl values decreased, the AUC values for saxagliptin (and its metabolite) either increased or became more variable</td>
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<td>Single 10 mg dose</td>
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<td>n=40 (normal RF, CKD 2, CKD 3, CKD 4, and CKD 5)&lt;sup&gt;6&lt;/sup&gt;</td>
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</table>

Notes:
- CL<sub>0–24</sub>, half-life; t<sub>max</sub>, time to reach maximum concentration; T2D, type 2 diabetes.
- Safety data not described.

**Study design**
- Single dose/multiple 5 mg dose
- Open-label, parallel-group study
- Multicenter, open-label, parallel-group study
- 50 mg od for 14 days
- 50 mg od for 14 days
- n=96 (normal RF, CKD 2, CKD 3, CKD 4, and CKD 5)<sup>4</sup>
- n=48 (normal RF, CKD 2, CKD 3, CKD 4, and CKD 5)<sup>6</sup>
- n=30 (normal RF, CKD 2, CKD 3, CKD 4, and CKD 5)<sup>6</sup>
- n=30 (normal RF, CKD 2, CKD 3, CKD 4, and CKD 5)<sup>6</sup>
- n=30 (normal RF, CKD 2, CKD 3, CKD 4, and CKD 5)<sup>6</sup>
- n=40 (normal RF, CKD 2, CKD 3, CKD 4, and CKD 5)<sup>6</sup>
- n=145

**PK findings**
- Compared with healthy individuals, increases in C<sub>max</sub> and AUC<sub>0–∞</sub> were observed in patients with stages 2, 3, 4, and 5 CKD.
- Increases were 1.4, 1.4, 1.8, and 1.4, respectively.
- AUC<sub>0–∞</sub> increased as CKD increased.
- T<sub>max</sub> was significantly increased in patients with stage 5 CKD and the t<sub>1/2</sub> increased with increasing CKD.

**Safety**
- Generally safe and well tolerated in both healthy individuals and patients with varying degrees of renal impairment.
- No SAEs or clinically relevant changes in clinical laboratory tests, vital signs, or ECG findings were reported.
- No deaths and no SAEs occurred, and no AEs led to discontinuation of study.

**Clearance**
- Vildagliptin: 13 L/h<sup>77</sup>
- Saxagliptin: 230 mL/min<sup>60</sup>
- Linagliptin: 70 mL/min<sup>60</sup>

**Enterohepatic system**
- Linagliptin: 70% unchanged as parent, 21%–52% as metabolite<sup>76</sup>
- Saxagliptin: 76% of the vildagliptin dose is excreted renally<sup>76</sup>
- Linagliptin: 6% renal (with and without T2D), and 70% unchanged as parent<sup>70</sup>
<table>
<thead>
<tr>
<th>Drug</th>
<th>Mode of action</th>
<th>PK findings</th>
<th>Safety data</th>
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| Linagliptin | Blocks DPP-IV, which degrades incretins[^10]  
Facilitates GLP-1-mediated insulin secretion[^11] | *There was a trend toward slightly higher (20%–60%) linagliptin exposure in patients with renal impairment.  
However, steady-state AUC and C[^\text{max}] values showed a large overlap and were not affected by the degree of CKD.  
DPP-IV concentration at baseline showed no relationship with CKD severity.* | No deaths and no SAEs occurred, and no AEs led to discontinuation of study medication.  
During treatment, two patients (4%) reported AEs considered related to linagliptin by the investigator: one case of mild headache and one case of mild diarrhe and mild fatigue.  
No other clinically significant AEs were observed. |
| Alogliptin | Blocks DPP-IV, which degrades incretins[^10]  
Facilitates GLP-1-mediated insulin secretion[^11] | Approximate 7.2% of the 50 mg dose was removed after 3 hours of dialysis in patients with stage 5 CKD.  
Mean C[^\text{max}] increased from 1.1- to 1.4-fold in renally impaired patients compared with healthy individuals.  
Plasma exposure to the minor active metabolite was low in all patients.  
Approximately 7.2% of the 50 mg dose was removed after 3 hours of dialysis in patients with stage 5 CKD.  
Protein binding was ~20% for each group. | Safety data not described. |

[^10]: Study used criterion for degree of Ri by CrCl: normal, >80 mL/min; CKD 2, 50–80 mL/min; CKD 3, 30–50 mL/min; CKD 4, <30 mL/min; CKD 5, ESRD.  
[^11]: Study used same criterion as DPP-IV inhibitors, but used the CrCl range of 51–80 mL/min for CKD 2.

**Abbreviations:** AE, adverse event; AUC, area underneath the curve; AUC[^\text{inf}^], AUC extrapolated to infinity; C[^\text{max}], maximum concentration; CrCl, creatinine clearance; DPP-IV, dipeptidyl peptidase-IV; ECG, electrocardiogram; ESRD, end-stage renal disease; GFR, glomerular filtration rate; GLP-1, glucagon-like peptide-1; od, once daily; PK, pharmacokinetics; RF, renal function; RI, renal impairment; SAE, serious adverse event; t[^\text{1/2}], half-life; t[^\text{max}], time to reach maximum concentration; T2D, type 2 diabetes.
Drug Administration requirements. Patients with no renal impairment or stage 2 CKD (P<0.0001) and stages 3–4 CKD (P=0.041) randomized to saxagliptin had greater improvement and less worsening of urine albumin-to-creatinine ratio (UACR) than patients randomized to placebo. Indeed, the relative risk of hospitalization for heart failure was comparable among patients with normal renal impairment or stage 2 CKD and patients with stages 3 and 4 CKD (P=0.43).

One PK study showed that, compared with patients with normal renal function, saxagliptin AUC extrapolated to infinity values were 16%–108% increased in those with stages 2–4 CKD. In addition, as CrCl values decreased, AUC values either increased or became more variable.

In treatment, no dose adjustment of saxagliptin is recommended for patients with stage 2 CKD, however, to keep the plasma concentration comparable to individuals with normal renal function, the dose should be reduced to 2.5 mg od in patients with stages 3–4 CKD. However, saxagliptin is contraindicated in patients with stage 5 CKD requiring hemodialysis.

Linagliptin
Linagliptin is metabolized by the liver and does not have active metabolites. It is eliminated by the enterohepatic system (>70% unchanged as parent) and the kidney (<6%). Linagliptin binds extensively to plasma proteins in a concentration-dependent manner and it has been calculated that, at the therapeutic dose (5 mg), most of the drug is protein-bound. In a study in which linagliptin was administered to patients with T2D and renal dysfunction, there was a significant reduction in albuminuria. In one PK study, although there was a trend toward slightly higher (20%–60%) linagliptin exposure in patients with CKD, steady-state AUC and Cmax values showed a substantial overlap and were unaffected by the degree of CKD. No deaths or serious AEs occurred, and no AEs led to discontinuation. During treatment, two patients reported AEs considered related to linagliptin by the investigator. No other clinically significant AEs were observed.

In treatment, in patients with CKD, no dose adjustment is required, and it can be administered across the CKD spectrum.

Alogliptin
Alogliptin is eliminated slowly, primarily via renal excretion (>70% unchanged as parent). After oral administration, alogliptin is absorbed with 100% bioavailability and undergoes ∼20% protein binding and limited hepatic metabolism. In a study by Sakata et al., alogliptin reduced UACR following 12 weeks of treatment.

In a PK study involving patients with various degrees of renal impairment (not stated whether any patients had T2D), Karim et al. determined that, compared with healthy individuals, increases in alogliptin exposure were 1.7–3.8-fold higher in patients with stages 2–5 CKD. The range of alogliptin AUC was comparable in healthy individuals and patients with stage 2 CKD. Cmax increased from 1.1- to 1.4-fold in patients with CKD compared with healthy individuals. Plasma exposure suggested no accumulation of this metabolite in patients with increasing CKD. Approximately 7.2% of the 50 mg dose was eliminated after 3 hours of dialysis in patients with stage 5 CKD. Protein binding was ~20% for each CKD group.

In patients with stage 2 CKD (in the CrCl range ≥50 to ≤80 mL/min), no alogliptin dose adjustment is required. For patients with stage 3 CKD (in the CrCl range ≥30 to ≤50 mL/min), half of the recommended dose should be administered (12.5 mg od) to keep the plasma concentration comparable to healthy individuals. Likewise, for patients with stages 4–5 CKD requiring dialysis, administration of a quarter of the recommended dose is advised (6.25 mg od).

Summary of DPP-IV inhibitor use in renal impairment
DPP-IV inhibitors can be used at all stages of CKD with dose reduction, except for linagliptin, which can be used without dose adjustment. A potential renoprotective effect (reduction in albuminuria) has been observed with all DPP-IV inhibitors. It is not clear whether this renoprotective effect is independent of changes in blood pressure and glycemic markers.

GLP-1 receptor agonists
GLP-1RAs function as incretin mimetics, which enhance the action of the endogenous incretin GLP-1, thereby controlling glycemia via several pathways, including enhancement of insulin secretion, inhibition of glucagon secretion, delay of gastric emptying, and induction of satiety. GLP-1RAs reduce HbA1c by 0.55%–1.90% and have low rates of hypoglycemia, with the advantage of promoting weight loss as well as controlling blood glucose. Owing to the effect of these agents on gastric emptying, AEs are typically gastrointestinal, that is, nausea and vomiting. However, gradually increasing the dose over a few weeks helps build a tolerance to such side effects. One possible, but infrequent, AE is pancreatitis.
Available evidence suggests that the rate of pancreatitis among patients using GLP-1-RAs is low; however, these data are not definitive and ongoing analysis is needed.

The short-acting compounds (short-lived receptor activation) consist of exenatide twice daily (bid) and lixisenatide od; the longer-acting compounds, which continuously activate receptors at their recommended dose, consist of liraglutide od and once weekly (ow) formulations of exenatide, albiglutide, and dulaglutide. Exenatide and liraglutide have been shown to reduce albuminuria and proteinuria, respectively. A summary of the MOAs, elimination, PK, and safety of the GLP-1-RAs is provided in Table 6.

Exenatide
Exenatide is a synthetic analog of exendin-4, which is extracted from the saliva of Heloderma suspectum. Exenatide bid and ow are both eliminated mainly by glomerular filtration with subsequent proteolytic degradation. In addition, Zhang et al reported decreased levels of 24-hour urinary albumin after 16 weeks of exenatide treatment (P<0.01).

In a study by Linnebjerg et al, exenatide (5 or 10 μg) was injected subcutaneously in 31 patients (including one patient with T2D) stratified by renal function (CrCl): normal and stages 2–5 CKD. PK data were then combined with four previous single-dose studies in patients with T2D to determine the relationship of exenatide clearance and CrCl. The half-life for patients with normal renal function and stages 2–5 CKD groups was 5.19–8.14 L/h. Similar category and incidence of AEs were reported between the healthy and stages 2 and 5 CKD groups. No AEs were reported for the group with stage 3 CKD and no patients discontinued because of AEs.

No dose adjustment is required at stage 2 CKD to maintain therapeutic exposure. In treatment, monitoring is required with lixisenatide in patients whose CrCl is in the range 30–50 mL/min (which falls within the definition of stages 3a and 3b CKD). Additionally, lixisenatide is contraindicated in patients with stages 4 and 5 CKD.

Liraglutide
Liraglutide has 97% sequence homology to GLP-1. Liraglutide is endogenously metabolized in a similar process to large proteins with no specific organ established as a major route of elimination. Zavattaro et al have shown a decrease in the proportion of patients with microalbuminuria; five patients in the study had microalbuminuria at baseline, but at 12 months, the levels in three of the patients had returned to normal (P<0.006). Total microalbuminuria levels were improved in patients with normal renal function and stage 2 CKD (P<0.02). Investigating the superiority of liraglutide 1.8 mg versus placebo as an add-on to existing oral glucose-lowering agents with T2D and stage 3 CKD, the LIRA-RENAL study showed that liraglutide did not affect renal function and demonstrated better glycemic control (estimated treatment difference in HbA1c from baseline was –0.66% [95% CI: –0.90 to –0.43; P<0.0001]). Moreover, no difference in hypoglycemic AEs was reported between treatment groups; common AEs were gastrointestinal (liraglutide, 35.7%; placebo, 17.5%).

Jacobsen et al investigated the effect of renal impairment on the PK of liraglutide in patients with T2D and normal renal function or stages 2–5 CKD. No defined relationship
<table>
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<tr>
<th>Licensed drug</th>
<th>Mode of action</th>
<th>Mode of excretion</th>
<th>Study design</th>
<th>PK</th>
<th>Safety</th>
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<tbody>
<tr>
<td>Exenatide</td>
<td>• Enhancement of insulin secretion</td>
<td>• Mainly by glomerular filtration with proteolytic degradation</td>
<td>• Linnebjerg et al (2007)</td>
<td>• Mean exenatide t½ values for patients with normal RF and stages 2, 3, and 5 CKD patients were 1.5, 2.1, 3.2, and 6.0 hours, respectively</td>
<td>• Category and frequency of AEs were comparable between the control (10 μg), CKD 2 (10 μg), and CKD 5 groups (5 μg)</td>
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<td></td>
<td>• Inhibition of glucagon secretion</td>
<td></td>
<td>• Open-label study</td>
<td></td>
<td>• No AEs were observed for the group with CKD 3 (5 and 10 μg exenatide)</td>
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<td></td>
<td>• Delay of gastric emptying and induction of satiety</td>
<td></td>
<td>• Single sc injection of 5 or 10 μg</td>
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<td>• No patients discontinued the study because of AEs</td>
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<td>n=31 (normal RF, CKD 2, CKD 3, and CKD 5)</td>
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<tr>
<td>Lixisenatide</td>
<td>• Enhancement of insulin secretion</td>
<td>• Elimination is mediated by glomerular filtration followed by tubular reabsorption and metabolic degradation</td>
<td>• Liu and Ruus (2009)</td>
<td>• No significant differences in AUC0−∞ or Cmax were reported for patients with stage 2 CKD compared with individuals with normal RF (AUC0−∞ ratio: 0.94; Cmax ratio: 0.98), or for patients with stage 3 CKD compared with normal RF (AUC0−∞ ratio: 1.28; Cmax ratio: 0.99)</td>
<td>• Treatment-emergent AEs were observed in one patient in each group with RI and four in the healthy group</td>
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<td></td>
<td>• Inhibition of glucagon secretion</td>
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<td>• AEs included headache (n=4, all with placebo), mild GI disturbance (n=4), and mild muscle tightness (n=1)</td>
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<td></td>
<td>• Delay of gastric emptying and induction of satiety</td>
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<tr>
<td>Liraglutide</td>
<td>• Enhancement of insulin secretion</td>
<td>• A similar process to large proteins without a specific organ as a major route of elimination</td>
<td>• Jacobsen et al (2009)</td>
<td>• Comparing individuals with normal RF with patients with CKD, exposure ratios were 0.67, 0.86, 0.73, and 0.74 in patients with stages 2, 3, 4, and 5 CKD, respectively</td>
<td>• Severity of CKD showed no relationship with an increased risk of AEs</td>
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<tr>
<td></td>
<td>• Inhibition of glucagon secretion</td>
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<td>• AEs were mild or moderate</td>
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<td>• Delay of gastric emptying and induction of satiety</td>
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<td>• Nine patients (three healthy, one in each of the CKD 2 and CKD 3 groups, and two in each of the CKD 4 and CKD 5 groups) reported eleven AEs related to the GI system and established as probably/possibly related to liraglutide</td>
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<tr>
<td>Dulaglutide</td>
<td>• Enhancement of insulin secretion</td>
<td>• Degradation into amino acids</td>
<td>• Loghin et al (2014)</td>
<td>• Dulaglutide AUC and Cmax was &lt;30% higher in patients with RI compared with individuals with normal RF</td>
<td>No notable differences in safety profiles between patients with RI and healthy individuals</td>
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<tr>
<td></td>
<td>• Inhibition of glucagon secretion</td>
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<tr>
<td></td>
<td>• Delay of gastric emptying and induction of satiety</td>
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**Abbreviations:** AUC, area under the curve; Cmax, maximum concentration; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate; GI, gastrointestinal; GLP-1 RA, glucagon-like peptide-1 receptor agonist; PK, pharmacokinetics; RF, renal function; RI, renal impairment; T2D, type 2 diabetes; Vmax, maximum velocity.
Albiglutide
- Enhancement of insulin secretion
- Inhibition of glucagon secretion
- Delay of gastric emptying and induction of satiety

Degradation into amino acids
- Clearance: 67 mL/h
- Young et al (2014)
- Nonrandomized, open-label study
- Single 30 mg dose
- n=41
- Normal RF, CKD 3, CKD 4, and CKD 5
- Also, a pooled analysis of four Phase III, randomized, double-blind (one open-label) studies:
  - 30-50 mg dose
  - n=1,113
  - Normal RF, CKD 2, CKD 3, and CKD 4
- Relative to individuals with normal RF, single-dose AUC ratios were 1.32, 1.39, and 0.99 for patients with stages 3, 4, and 5 CKD, respectively
- Relative to individuals with normal RF, single-dose C<sub>max</sub> ratios were 1.21, 1.23, and 1.11 for patients with stages 3, 4, and 5 CKD, respectively
- In the pooled analysis, there was a trend for increased glycemic lowering as CKD severity increased

Elimination of albiglutide
- Mainly by glomerular secretion
- Open-label study in 5 CKD patients were 1.5, 2.1, 3.2, and 3.3 μg, and CKD 5 = 4.3 μg
- Mean exenatide t<sub>1/2</sub> values for patients with normal RF individuals and stages 2, 3, and 5 CKD were 8.14, 5.19, 7.11, and 1.30 L/h, respectively
- No significant differences in AUC ratios were 1.32, 1.39, and 0.99 for patients with stages 3, 4, and 5 CKD, respectively
- Treatment-emergent AEs were comparable in the normal, and stages 2 and 3 CKD groups; in contrast, the stage 4 CKD group demonstrated comparatively lower rates
- The SAEs showed a trend upward from the normal RF to the stage 3 CKD patients, but the stage 4 CKD group reported no SAEs
- Withdrawal incidence due to AEs was generally low but higher in the groups with R1

Notes: Study used criterion for degree of RI by CrCl: normal, >80 mL/min; CKD 2, 31–50 mL/min; CKD 3, 11–30 mL/min; CKD 5, ESRD.
Study used criterion for degree of RI by CrCl: normal, >80 mL/min; CKD 2, 31–50 mL/min; CKD 3, 11–30 mL/min; CKD 4, <30 mL/min. Study used criterion for degree of RI by CrCl: normal, >80 mL/min; CKD 2, >50 and ≤80 mL/min; CKD 3, >20 and ≤40 mL/min; CKD 4, ≤30 mL/min; CKD 5, ≤30 mL/min; CKD 6, ESRD.

Abbreviations: AE, adverse event; AUC, area under the curve; AUC<sub>max</sub>, AUC up to the last measurable concentration; CKD, chronic kidney disease; CL/F, apparent clearance; CL<sub>0.1</sub>/f, excreted clearance; C<sub>max</sub>, maximum concentration; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate; ESRD, end-stage renal disease; GI, gastrointestinal; GLP-1 RA, glucagon-like peptide-1 receptor agonist; PK, pharmacokinetics; RF, renal function; RI, renal impairment; SAE, serious adverse event; sc, subcutaneous; t<sub>1/2</sub>, half-life; T2D, type 2 diabetes.

Dulaglutide
- 90% sequence homology to GLP-1,
- Dulaglutide is a once-weekly GLP-1 RAA
- The GLP-1 portion of the molecule fused to an immunoglobulin 4 molecule
- In their investigation of the PK of albiglutide in patients with T2D stages 2–5 CKD groups, Young et al determined amino acids by ubiquitous prolylcarboxypeptidases (PCPs) in patients with altered PCP activity.
- Albiglutide is a dimer fused to an albumin molecule
- The expected metabolic pathway for degradation of albiglutide is demonstrated by its tendency to be degraded in patients with altered PCP activity.
- Dulaglutide has the same PK parameters in renal impairment compared to healthy individuals. The study included stages 2–5 CKD populations. There was no significant linear correlation between exposure and CrCl. A weak statistically significant correlation was established between albiglutide exposure and CrCl, and dulaglutide clearance. There were no prominent differences in safety profiles between patients with CKD and healthy individuals.
- In treatment, no dose adjustment of dulaglutide is necessary in patients with stages 2–3 CKD, but there is need for dose adjustment in patients with stages 4–5 CKD. Elimination of dulaglutide is not correlated with renal function.
- In treatment, no dose adjustment is necessary for patients with stages 2–3 CKD. As there is no therapeutic knowledge in patients with stages 4–5 CKD, liraglutide is contraindicated for use in patients with these diagnoses.
- From the pooled analysis:
  - Overall, nonserious AEs were reported at a comparable rate between the normal RF individuals and the stages 2–3 CKD groups; in contrast, the stage 4 CKD group demonstrated comparatively lower rates
  - The SAEs showed a trend upward from the normal RF to the stage 3 CKD patients, but the stage 4 CKD group reported no SAEs
  - Withdrawal incidence due to AEs was generally low but higher in the groups with RI

Notes: Study used criterion for degree of RI by CrCl: normal, >80 mL/min; CKD 2, 31–50 mL/min; CKD 3, 11–30 mL/min; CKD 5, ESRD.
Study used criterion for degree of RI by CrCl: normal, >80 mL/min; CKD 2, >50 and ≤80 mL/min; CKD 3, >30 and ≤50 mL/min; CKD 4, ≤30 mL/min; CKD 5, ≤30 mL/min; CKD 6, ESRD.

Abbreviations: AE, adverse event; AUC, area under the curve; AUC<sub>max</sub>, AUC up to the last measurable concentration; CKD, chronic kidney disease; CL/F, apparent clearance; CL<sub>0.1</sub>/f, excreted clearance; C<sub>max</sub>, maximum concentration; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate; ESRD, end-stage renal disease; GI, gastrointestinal; GLP-1 RA, glucagon-like peptide-1 receptor agonist; PK, pharmacokinetics; RF, renal function; RI, renal impairment; SAE, serious adverse event; sc, subcutaneous; t<sub>1/2</sub>, half-life; T2D, type 2 diabetes.
In treatment, no dose adjustment of albiglutide is required for patients with stages 2–3 CKD. There is limited experience in patients with stages 4–5 CKD, and, therefore, albiglutide is contraindicated in these patients.\textsuperscript{65}

Summary of GLP-1RA use in renal impairment

Dose adjustment is required in exenatide bid in patients whose CrCl is in the range 30–50 mL/min, which falls within the definition of stages 3a and 3b CKD.\textsuperscript{56,61} within the same CrCl range, exenatide ow is contraindicated.\textsuperscript{62} Also, within the same range, monitoring is necessary when dosing lixisenatide.\textsuperscript{63} By contrast, no dose alteration is necessary for liraglutide, albiglutide, and dulaglutide in stages 2, 3a, and 3b CKD.\textsuperscript{64,66} All GLP-1RAs are currently contraindicated in stages 4–5 CKD.\textsuperscript{61–66}

SGLT-2 inhibitors

SGLT-2 inhibitors inhibit glucose reabsorption and induce excretion of glucose in the urine.\textsuperscript{109} Treatment with SGLT-2 inhibitors is associated with reductions in HbA\textsubscript{1c} levels of 0.4%–1.5% and weight of up to 4.7 kg.\textsuperscript{110,111}

SGLT-2 inhibitors carry a low risk of hypoglycemia, unless combined with sulfonylureas or insulin.\textsuperscript{112} AEs include urinary and genital tract infections (which are usually not severe), especially in female patients.\textsuperscript{112} SGLT-2 inhibitors appear to be associated with a small increased risk of euglycemic diabetic ketoacidosis and ketosis.\textsuperscript{112,113}

As their efficacy is reliant on renal function, SGLT-2 inhibitors are generally contraindicated in patients with eGFR < 60 mL/min/1.73 m\textsuperscript{2}, mainly because of reduced efficacy.\textsuperscript{72}

A summary of their MOAs, elimination, PK, and safety is provided in Table 7.

Dapagliflozin

Dapagliflozin is metabolized in both the kidney and the liver, with active metabolites generated at doses of >50 mg.\textsuperscript{119} It is primarily eliminated via the renal pathway.\textsuperscript{67}

Assessment of PK by Kasichayanula et al\textsuperscript{114} in healthy individuals and patients with T2D with normal renal function and stages 2–4 CKD showed that dapagliflozin plasma concentrations and its inactive metabolite dapagliflozin 3-O-glucuronide increased with increasing CKD severity. Steady-state C\textsubscript{max} values for dapagliflozin were 4%–9% higher, and for dapagliflozin 3-O-glucuronide were 20%–52% higher in T2D patients with stages 2–4 CKD, compared with patients with T2D and normal renal function.\textsuperscript{114} Steady-state renal glucose clearance was reduced by 42%–84% in patients with stages 2–4 CKD, thereby also reducing its efficacy.\textsuperscript{114}

In treatment, dapagliflozin is not recommended for use in patients with stages 3–5 CKD.\textsuperscript{68} However, no dosage adjustment is suggested in patients with stage 2 CKD.

Canagliflozin

Canagliflozin is primarily metabolized by O-glucuronidation.\textsuperscript{119} It is eliminated largely unchanged in the feces (41.5%) and as metabolites in the urine (30.5%). Recent clinical data suggest that, in addition to the renal mechanism of action, a nonrenal mechanism partially contributes to glucose lowering for canagliflozin 300 mg but not 150 mg.\textsuperscript{115} Data from a substudy of the CANagliflozin cardioVascular Assessment Study (CANVAS) showed that 100 and 300 mg doses of canagliflozin significantly reduced the primary outcome of HbA\textsubscript{1c} levels relative to placebo at week 18 (both P<0.001).\textsuperscript{120}

A study examining the impact of CKD on the PK and PD of canagliflozin 100 and 200 mg in Japanese patients with T2D found no significant effect of stage 3 CKD on the C\textsubscript{max} of either canagliflozin dose.\textsuperscript{121} The canagliflozin AUC values were higher in patients with stage 3 CKD than in patients with T2D and normal renal function or stage 2 CKD. Changes from baseline in 24-hour urinary glucose excretion increased after administration but, in patients with stage 3 CKD, the increases were ∼70% of those in patients with stage 2 CKD or normal.

In treatment, in patients with stage 2 CKD, no dose adjustment is needed.\textsuperscript{66} Canagliflozin should not be initiated in patients with eGFR < 60 mL/min/1.73 m\textsuperscript{2}, but in patients tolerating canagliflozin whose eGFR falls continuously below 60 mL/min/1.73 m\textsuperscript{2}, the dose of canagliflozin should be reduced to or managed at 100 mg od. Canagliflozin is contraindicated in patients with stages 3b–5 CKD, and in patients undertaking dialysis.

Empagliflozin

Empagliflozin is metabolized by glucuronidation without generation of active metabolites and eliminated in feces (41%) and urine (54%).\textsuperscript{69}

In a study comparing patients with normal renal function (and T2D), stage 2 CKD (and T2D), stage 3 CKD (and T2D), stage 4 CKD (four patients with T2D and four without), and stage 5 CKD (without T2D), Macha et al\textsuperscript{118} showed that the C\textsubscript{max} for empagliflozin was similar for stages 3 and 5 CKD and with normal renal function (and T2D). However, empagliflozin C\textsubscript{max} values were ∼20% higher for patients with stages 2 and 4 CKD than for patients with normal renal function.\textsuperscript{118}
Table 7  SGLT-2 inhibitors: modes of action, modes of excretion, and studies investigating PK and PD

<table>
<thead>
<tr>
<th>Licensed drug</th>
<th>Mode of action</th>
<th>Mode of excretion</th>
<th>Study design</th>
<th>PK</th>
<th>PD</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dapagliflozin</td>
<td>Inhibition of SGLT-2, a high-capacity and low-affinity glucose transporter, expressed in the luminal membranes of the proximal renal tubules</td>
<td>Primarily renal</td>
<td>Kasichayanula et al (2013)</td>
<td>Steady-state C_max values for dapagliflozin were 4%, 6%, and 9% higher, and for D30G were 20%, 37%, and 52% higher in T2D patients with stages 2, 3, and 4 CKD, respectively, versus T2D patients with normal RF</td>
<td>Reduced steady-state renal glucose clearance by 42%, 83%, and 84% in patients with stages 2, 3, and 4 CKD, respectively</td>
<td>35% of participants experienced AEs, which were all mild or moderate in intensity</td>
</tr>
<tr>
<td>Canagliflozin</td>
<td>Inhibition of SGLT-2, a high-capacity and low-affinity glucose transporter, expressed in the luminal membranes of the proximal renal tubules</td>
<td>In feces (41.5%) and as metabolites in the urine (30.5%)</td>
<td>Inagaki et al (2014)</td>
<td>No significant effect in those with CKD 3 on C_max</td>
<td>Urinary glucose excretion increased after administration of both doses</td>
<td>No AEs leading to study discontinuation, deaths, other SAEs, or other significant AEs</td>
</tr>
<tr>
<td>Empagliflozin</td>
<td>Inhibition of SGLT-2, a high-capacity and low-affinity glucose transporter, expressed in the luminal membranes of the proximal renal tubules</td>
<td>In feces (41%) and urine (54%)</td>
<td>Macha et al (2014)</td>
<td>AUC values increased by ∼18%, 20% 66%, and 48% in patients with stages 2, 3, 4, and 5 CKD, respectively, in comparison with healthy individuals</td>
<td>Urinary glucose excretion decreased with increasing CKD severity and correlated with decreased eGFR and Cl_R</td>
<td>Six treatment-emergent AEs were reported by four patients; all were mild in intensity</td>
</tr>
</tbody>
</table>

Notes: Study used criterion for degree of RI by CrCl: normal, >80 mL/min; CKD 2, 51–80 mL/min; CKD 3, 30–50 mL/min; CKD 4, <30 mL/min; CKD 5, ESRD. Study used criterion for degree of RI by eGFR: normal, $\geq 90$ mL/min/1.73 m²; CKD 2, 60–89 mL/min/1.73 m²; CKD 3, 30–59 mL/min/1.73 m²; CKD 4, <30 mL/min/1.73 m²; CKD 5, ESRD. Study used criterion for degree of RI by eGFR: normal, $\geq 90$ mL/min/1.73 m²; CKD 2, 60–89 mL/min/1.73 m²; CKD 3, 30–59 mL/min/1.73 m²; CKD 4, <30 mL/min/1.73 m²; CKD 5, ESRD.

Abbreviations: AE, adverse event; AUC, area under the curve; AUC_{\text{max}}, AUC extrapolated to infinity; CKD, chronic kidney disease; Cl_R, clearance; C_{\text{max}}, maximum concentration; D30G, dapagliflozin 3-O-glucuronide; eGFR, estimated glomerular filtration rate; ECG, electrocardiogram; ESRD, end-stage renal disease; od, once daily; PD, pharmacodynamics; PK, pharmacokinetics; RF, renal function; RI, renal impairment; SAE, serious adverse event; SGLT-2, sodium-glucose cotransporter-2; T2D, type 2 diabetes.
In treatment, no dose adjustment of empagliflozin is necessary for patients with stage 2 CKD, but empagliflozin treatment should not be administered in patients with eGFR <60 mL/min/1.73 m². In patients tolerating empagliflozin whose eGFR falls continuously beneath 60 mL/min/1.73 m², the dose of empagliflozin should be altered or managed at 10 mg od and stopped when eGFR is continuously beneath 45 mL/min/1.73 m². Empagliflozin is contraindicated in patients with stages 3b to 5 CKD.69

SGLT-2 effect on proteinuria

Many studies have shown evidence of renoprotection with use of SGLT-2 inhibitors in patients with CKD.120,122–124 SGLT-2 inhibition may mediate their renoprotective effects by decreasing intra-glomerular pressure.122 Indeed, inhibition of SGLT-2 can normalize the NaCl concentration at the macula densa and lower glomerular hyperfiltration, thereby lowering glomerular hyperfiltration and albuminuria.125 This MOA could explain the reduction of albuminuria with SGLT-2 (dapagliflozin, canagliflozin, and empagliflozin) treatment described in clinical studies.120,122–124

In a study by Kohan et al,122 UACR values of >1,800 mg/g during the 104-week treatment period were reported in a higher percentage of patients receiving placebo (13.3%) than patients receiving dapagliflozin 5 (10.8%) or 10 mg (9.5%), indicating decreased albuminuria with dapagliflozin. In Phase III studies, canagliflozin treatment was also associated with decreased albuminuria and an early decrease in eGFR.120,124 Yale et al124 determined a lower proportion of subjects in the canagliflozin 100 and 300 mg groups progressing from normoalbuminuria to micro- or macroalbuminuria, or from micro- to macroalbuminuria compared to those in the placebo group (5.1%, 8.3%, and 11.8%, respectively); likewise, the CANVAS substudy reported decreases in UACR from baseline at canagliflozin 100 mg (−9.6, 95% CI: −13.0 to −6.1) and 300 mg doses (−9.5, 95% CI: −12.9 to −6.1).120

In the Efficacy and Safety of Empagliflozin (BI 10773) in Patients With Type 2 Diabetes and Renal Impairment (EMPAREG RENAL) placebo-controlled trial, small decreases in eGFR and albuminuria were shown in empagliflozin-treated T2D patients with stages 2–3 CKD.123 UACR was enhanced with empagliflozin (10 and 25 mg) after 52 weeks in patients with stage 2 CKD (empagliflozin 10 mg placebo adjusted mean difference: −184.59, P=0.0831; at 25 mg: −235.86, P=0.0257) and stage 3 CKD (empagliflozin 25 mg placebo adjusted mean difference: −183.78, P=0.0031). Moreover, greater proportions of patients with stage 3 CKD shifted from macroalbuminuria at baseline to microalbuminuria, or from microalbuminuria to no albuminuria with empagliflozin compared to placebo (32.6% vs 8.6% and 27.5% vs 21.4%, respectively).

Summary of SGLT-2 inhibitor use in renal impairment

For patients with stage 3 CKD or greater, SGLT-2 inhibitors (dapagliflozin, canagliflozin, and empagliflozin) either require dose adjustment or are contraindicated.67–69 However, a renoprotective effect has been observed with all SGLT-2 inhibitors.120,122–124

Impact of CKD on treatment algorithm

Leading on to the impact of CKD on the T2D treatment algorithm, examples of the dose maintenance and withdrawal of glucose-lowering therapies in the American Diabetes Association/European Association for the Study of Diabetes 2015 guidelines are described in Figure 1.

Ongoing or data pending studies

Clinical investigations of DPP-IV inhibitor, GLP-1RA, and SGLT-2 inhibitor therapies in renal impairment or protection are being carried out in several ongoing studies. A summary is provided in Table 8.

Incretin-based therapies

The Differential Effects of Diabetes Therapy on Inflammation study aims to determine whether different diabetes treatments have different effects on inflammation, particularly in the kidney, and includes126 patients who need additional glycemic therapy and who are prescribed a DPP-IV inhibitor, GLP-1RA, or insulin.126

Given the relationship between CV safety and T2D and the uncertainty surrounding the CV risk of some therapies, the Cardiovascular and Renal Microvascular Outcome Study with Linagliptin in Patients With Type 2 Diabetes Mellitus (CARMELINA) will compare the CV and renal safety of linagliptin versus placebo, when added to standard care in 8,000 patients with T2D at high CV risk.127 Clinical data have previously shown that linagliptin reduces albuminuria.88,140 The Efficacy, Safety and Modification of Albuminuria in Type 2 Diabetes Subjects with Renal Disease with Linagliptin (MARLINA) study will investigate this renoprotective effect.128 The Renal Effects of DPP-IV Inhibitor Linagliptin in Type 2 Diabetes (RENALIS) study will further investigate this drug’s action on renal physiology.129 In addition, delayed elimination of GLP-1 and glucose-dependent insulinotropic polypeptide (GIP) in renal insufficiency may influence the PK and PD of linagliptin;141 consequently, another study will investigate the effects of linagliptin on active
GLP-1 concentrations in patients with renal impairment. Examining the safety of a DPP-IV inhibitor in a real-world setting, a postmarketing study will compare the rates of hospitalization for acute kidney injury among patients with T2D who are new initiators of saxagliptin and those patients who are new initiators of other T2D therapies. Several studies are currently examining the safety and renoprotective effects of GLP-1RAs. Cardiorenal syndrome type IV is impaired cardiac function due to CKD and is characterized by ventricular hypertrophy, diastolic dysfunction, and/or increased risk of CV AEs. The Extended Release Exenatide versus Placebo in Diabetic Patients with Type IV Cardiorenal Syndrome study is evaluating the quantitative impact of 38 weeks of treatment on cardiac biomarkers in patients at high risk of developing cardiorenal syndrome type IV. Additionally, the mechanistic and clinical effects of lixisenatide on renal physiology and biomarkers in T2D patients are being explored in the Effect of LIXIsenatide on renal physiology and biomarkers in T2D. The EMPA-REG RENAL trial showed that albuminuria decreased in T2D patients with stages 2–3 CKD treated with empagliflozin. To further investigate the impact of empagliflozin on renal kinetics, The Effect of Empagliflozin
Table 8 Ongoing or data pending studies

<table>
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<td></td>
<td>Efficacy, Safety and Modification of Albuminuria in Type 2 Diabetes</td>
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<td>Renal Effects of DPP-4 Inhibitor Linagliptin in Type 2 Diabetes</td>
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<td>(RENA LIS)[^29]</td>
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<td>Risk of Acute Kidney Injury Among Patients With Type 2 Diabetes</td>
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<td>Exposed to Oral Antidiabetic Treatments[^31]</td>
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<td>Extended Release Exenatide versus Placebo in Diabetic Patients with</td>
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<td>Type 4 Cardiorenal Syndrome (EXTEND-CRS)[^32]</td>
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<td>Effect of Liksenatide on the Renal System (ELIXIRS)[^33]</td>
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<td>The Effect of Glucagon-like-peptide 1 (GLP-1) Receptor Agonism on Diabetic Kidney Disease[^34]</td>
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<td>A Study Comparing Dulaglutide With Insulin Glargine on Glycemic Control in Participants With Type 2 Diabetes (T2D) and Moderate or Severe Chronic Kidney Disease (CKD) (AWARD-7)[^35]</td>
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<td>A Study to Evaluate the Effect of Dapagliflozin on Blood Glucose Level and Renal Safety in Patients With Type 2 Diabetes (DERIVE)[^36]</td>
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<td>A Study of the Effects of Canagliflozin (INJ-28431754) on Renal Endpoints in Adult Participants With Type 2 Diabetes Mellitus (CANVAS-R)[^37]</td>
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<td>Evaluation of the Effects of Canagliflozin on Renal and Cardiovascular Outcomes in Participants With Diabetic Nephropathy (CREDENCE)[^38]</td>
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<td>Effect of Empagliflozin Kinetics on Renal Glucose Reabsorption in Patients With Type II Diabetes and Healthy Controls[^39]</td>
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SGLT-2 therapies

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<th>ClinicalTrials.gov identifier</th>
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<td>A Study to Evaluate the Effect of Empagliflozin on Renal Impairment.</td>
<td></td>
<td>(no data presented)</td>
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</table>

Abbreviations: DPP-4, dipeptidyl peptidase-4; GLP-1, glucagon-like peptide-1; SGLT-2, sodium-glucose cotransporter-2.

Kinetics on Renal Glucose Reabsorption in Patients with Type II Diabetes and Healthy Controls study, which has no current published data, investigated the change from baseline of renal tubular maximum reabsorptive capacity for glucose at end of empagliflozin treatment[^139].

Conclusion

Improved blood glucose control through pharmacological intervention can reduce the incidence and progression of CKD.[^8,13,14] CKD is a common complication of T2D and should inform the choice of initial and subsequent drug therapy based on individualized glycemic targets.

Apart from the thiazolidinedione pioglitazone,[^20] which can be used across the spectrum of CKD, there are contraindications and dose adjustments required for all the remaining conventional therapies, including metformin, sulfonylureas, meglitinides, and insulin.[^21-33] The inclusion of several newer therapy classes in treatment guidelines increases the likelihood that T2D will be well managed,[^17] with the attendant positive impact on the long-term incidence and progression of renal impairment.

Clinical studies suggest that reductions in albuminuria may be renoprotective and have been observed with all DPP-IV inhibitors,[^76,84,86,88,90] all SGLT-2 inhibitors, as demonstrated in the EMPA-REG study,[^120,122,123] and the GLP-1RAs liraglutide and exenatide.[^96,105] However, as with conventional therapies, not all of these newer therapies can be used when CKD is present, and some require dose adjustment with incident CKD.[^56-58,60-63,66,69] In contrast to other DPP-IV inhibitors,[^56-58,60] linagliptin can be used across the spectrum of CKD with no dose adjustment.[^59] No dose adjustment is required for liraglutide, albiglutide, and dulaglutide in stages 2–3 CKD;[^64-66] however, they are all currently contraindicated in CKD stages 4–5.[^61-66] At CKD stages of 3 or more, the SGLT-2 inhibitors dapagliflozin, canagliflozin, and empagliflozin either require dose adjustment or are contraindicated.[^67-69]

Data from ongoing clinical trials with larger populations are awaited to further determine the safety and efficacy profile of DPP-4 inhibitors, GLP-1RAs, and SGLT-2 inhibitors in patients with T2D and CKD.[^126-139] Ongoing trials, such as CARMELINA, MARLINA, ELIXIRS, A Study Comparing...
Dulaglutide With Insulin Glargine on Glycemic Control in Participants With Type 2 Diabetes (T2D) and Moderate or Severe Chronic Kidney Disease (CKD) (AWARD-7), CREDENCE, and CANVAS-R, in particular, will help to confirm the position of these new therapy classes in patients with CKD.

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Author contributions
All authors contributed toward data analysis, drafting and revising the paper and agree to be accountable for all aspects of the work.

Disclosure
Professor Melanie Davies has acted as a consultant, advisory board member, and speaker for Novo Nordisk, Sanofi-Aventis, Eli Lilly, Merck Sharp and Dohme, Boehringer Ingelheim, AstraZeneca, and Janssen, and as a speaker for Mitsubishi Tanabe Pharma Corporation and Takeda. She has received grants in support of investigator-initiated trials from Novo Nordisk, Sanofi-Aventis, and Eli Lilly. Dr. Sudeesha Chatterjee has received speaker fees and educational funding from Janssen, Eli Lilly, Novo Nordisk, AstraZeneca, and Boehringer Ingelheim. Professor Kamlesh Khunti has received funds for research and honoraria for speaking at meetings from, and served on advisory boards for, AstraZeneca, Boehringer Ingelheim, Lilly, Novartis, Roche, Servier, Sanofi Aventis, MSD, Janssen, and Novo Nordisk. The authors report no other conflicts of interest in this work.

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