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POS-255 EFFECT OF DAPAGLIFLOZIN ON BLOOD PRESSURE IN PATIENTS WITH CKD: A PRE-SPECIFIED ANALYSIS FROM DAPA-CKD

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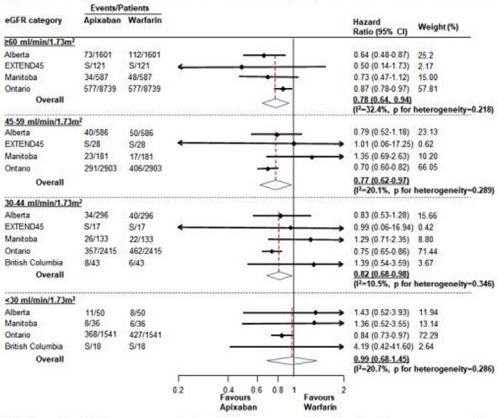
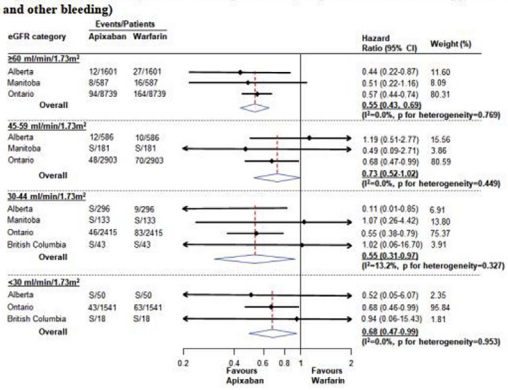
Figure 1: HRs (95% CIs) for the ischemic outcome (composite of ischemic stroke, TIA and all-cause mortality)



*Within each eGFR category, warfarin initiation was considered as the reference category in estimating the hazard ratios and their 95% CIs; S=the number of outcome events were <5 and cells were suppressed

Figure 2: HRs (95% CIs) for the bleeding outcome (composite of intracranial, upper or lower gastrointestinal and other bleeding)



*Within each eGFR category, warfarin initiation was considered as the reference category in estimating the hazard ratios and their 95% CIs; S=the number of outcome events were <5 and cells were suppressed

Conclusions: Apixaban initiation was associated with lower or similar risk of ischemic and bleeding outcomes across all eGFR categories. Our results suggest apixaban therapy offers a favourable risk-benefit ratio in patients with atrial fibrillation independent of eGFR.

No conflict of interest

POS-255

EFFECT OF DAPAGLIFLOZIN ON BLOOD PRESSURE IN PATIENTS WITH CKD: A PRE-SPECIFIED ANALYSIS FROM DAPA-CKD

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Introduction: Hypertension is common in patients with chronic kidney disease (CKD). Sodium-glucose cotransporter 2 inhibitors decrease blood pressure in patients with type 2 diabetes, but the consistency and magnitude of blood pressure lowering with dapagliflozin in patients with CKD is unknown. We performed a pre-specified analysis of the DAPA-CKD trial to investigate the effect of dapagliflozin on systolic blood pressure in patients with CKD, with and without type 2 diabetes.

Methods: We randomized 4,304 adults with baseline eGFR 25–75 mL/min/1.73m^{2}and urinary albumin-to-creatinine ratio (UACR) 200–5,000 mg/g to either dapagliflozin 10 mg or placebo once daily; median follow-up was 2.4 years. The primary outcome was a composite of sustained ≥50% eGFR decline, end-stage kidney disease, or death from a kidney or cardiovascular cause. Change in systolic blood pressure was a pre-specified endpoint. Subgroup analyses were performed according to baseline type 2 diabetes status.

Results: Baseline mean (SD) systolic blood pressure was 137.1 mmHg (17.4); in participants with and without type 2 diabetes 139.2 mmHg (17.3) and 132.6 mmHg (16.7), respectively. By week 2, dapagliflozin compared to placebo reduced systolic blood pressure by 3.6 mmHg (95%CI 2.8, 4.4; p<0.001), an effect maintained over the duration of the trial, with similar reductions in patients with and without type 2 diabetes (Table). The reduction in systolic blood pressure with dapagliflozin explained 7.6% (95%CI 1.8, 20.9) of the effect on the primary composite outcome, with similar proportions explained in patients with and without type 2 diabetes.

Table: Changes with dapagliflozin versus placebo in systolic blood pressure (SBP)

	Difference in SBP (mmHg) at week 2 (95%CI)	Difference in SBP (mmHg) over the duration of the trial (95%CI)	Proportion explained (95%CI)
Overall (N=4304)	-3.6 (-4.4, -2.8)	-2.9 (-3.6, -2.3)	7.6% (1.8, 20.9)
Type 2 diabetes (N=2906)	-4.2 (-5.1, -3.2)	-3.2 (-4.0, -2.5)	8.6% (1.3, 33.0)
No diabetes (N=1398)	-2.5 (-3.9, -1.1)	-2.3 (-3.4, -1.2)	3.6% (-9.9, 31.7)

'Proportion explained' indicates the percentage of the benefit of dapagliflon on the primary outcome explained by the reduction in systolic blood pressure at week 2.

Conclusions: In participants with CKD, dapagliflozin lowered systolic blood pressure with a consistent effect in participants with and without type 2 diabetes. The modest reduction in blood pressure explained a small proportion of the benefit of dapagliflozin on the primary outcome.

Conflict of interest

Potential conflict of interest:

HLH received grant funding and honoraria for consultancy as a member of the steering committee of the DAPA-CKD trial from AstraZeneca. Honoraria for steering committee membership paid to his institution from Janssen, Gilead, Bayer, Chinook, CSL Pharma honoraria for consultancy paid to his institution from Abbvie, Boehringer Ingleheim, Retrophin, Novo Nordisk honoraria for advisory board participation paid to his institution from Janssen, Merck, Mitsubishi Tanabe and Munipharma lecture fees received from AstraZeneca and Mitsubishi Tanabe and grant support received from Boehringer Ingelheim.

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EFFECTS OF HIGH ALTITUDE EXPOSURE ON SERUM HEMOGLOBIN LEVELS IN PATIENTS WITH CHRONIC KIDNEY DISEASE ON HEMODIALYSIS

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