

- circulatory death. *Clin J Am Soc Nephrol*. 2016;11:317-23, <http://dx.doi.org/10.2215/CJN.07190715>.
8. Summers DM, Watson CJE, Pettigrew GJ, Johnson RJ, Collett D, Neuberger JM, et al. Kidney donation after circulatory death (DCD): state of the art. *Kidney Int*. 2015;88:241-9, <http://dx.doi.org/10.1038/ki.2015.88>.
9. Suntharalingam C, Sharples L, Dudley C, Bradley JA, Watson CJE. Time to cardiac death after withdrawal of life-sustaining treatment in potential organ donors. *Am J Transplant*. 2009;9:2157-65, <http://dx.doi.org/10.1111/j.1600-6143.2009.02758.x>.
10. Peters-Sengers, Houtzager JHE, Heemskerk MBA, Idu MM, Minnee RC, Klaasen RW, et al. DCD donor hemodynamics as predictor of outcome after kidney transplantation. *Am J Transplant*. 2018;18:1966-76, <http://dx.doi.org/10.1111/ajt.14676>.

Iris Coello*, Ana Isabel Martínez, Maria Peraire, Laura Aizpiri, Camila Andrea Vega, Miquel Amer, Ricardo José Guldris, José L. Bauzá Quetglas, Enrique Carmelo Pieras

Servicio de Urología, Hospital Universitario Son Espases, Palma de Mallorca, Spain

* Corresponding author.

E-mail address: iris.coello@ssib.es (I. Coello).

2013-2514/© 2023 Published by Elsevier España, S.L.U. on behalf of Sociedad Española de Nefrología. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>). <https://doi.org/10.1016/j.nefro.2021.04.019>

Efficacy and safety of semaglutide in a diabetic and obese patient on incremental hemodialysis. Does it also contribute to preserving residual renal function?

Eficacia y seguridad de la semaglutide en un paciente diabético y obeso en hemodiálisis incremental. ¿Contribuye también a preservar la función renal residual?

Dear Editor,

Diabetic kidney disease is the most common cause of advanced chronic kidney disease.^{1,2} However, the therapeutic options continue to be limited for patients with diabetic kidney disease on maintenance haemodialysis. GLP-1 receptor agonists (GLP-1 RA) contribute to improving blood glucose control by reducing glycated haemoglobin (HbA1c).³ Other beneficial effects include feeling full, weight loss, increased natriuresis, lower blood pressure, decreased albuminuria and slowing down the progression of diabetic kidney disease.^{4,5} Despite this, its use in haemodialysis is rare.

We present the case of a 56-year-old man with high blood pressure, chronic obstructive pulmonary disease, advanced chronic kidney disease on pre-dialysis, type 2 diabetes mellitus treated with 32 IU of insulin detemir, 3 mg repaglinide and 5 mg linagliptin a day, with HbA1c at 8.5% and BMI 36.5 kg/m². In January 2021, he started incremental haemodialysis with one session/week (240 min) with an asymmetric cellulose triacetate dialyser (1.9 m²) (ATA[®]) due to uraemic symptoms, poor blood pressure control and moderate-severe hyperkalaemia. His serum creatinine was

6.97 mg/dl (estimated glomerular filtration rate using the CKD-EPI formula, 8.48 ml/min/1.73 m²), creatinine clearance (CrCl) and urea clearance (KrU) measured by 24-h urine 16 and 5.84 ml/min/1.73 m², respectively. His glomerular filtration rate measured by the half-sum of CrCl and KrU was 10.92 ml/min/1.73 m² and the albumin/creatinine ratio was 3200 mg/g.

In order to optimise the patient's blood-glucose control, semaglutide (0.25 mg/week) was added to the treatment, and linagliptin and repaglinide were discontinued. The doses were gradually increased to 1 mg over 12 weeks, with good tolerance and no episodes of hypoglycaemia, and the insulin dose was gradually reduced. At 24 weeks, the patient's HbA1c had decreased by 23.5%, weight by 10.2% and BMI by 10.5%. In addition, not only did his fat mass and total body water decrease by 16.4% and 12.2% respectively, his lean mass increased by 14% (Table 1). His glomerular filtration rate remained unchanged throughout the observed period. However, the two parameters evolved differently, with KrU increasing and CrCl decreasing. Urinary creatinine excretion normalised to kilograms of weight increased, and urea remained stable. His blood pressure and albumin/creatinine ratio also decreased (Table 1).

DOI of original article:

<https://doi.org/10.1016/j.nefro.2021.07.014>.

Table 1 – Changes over time in lab test and haemodialysis parameters.

	Baseline	Week 4	Week 8	Week 12	Week 24
Lab test, blood-glucose and body component control					
Hb (g/dl)	10.5	10.1	11	11.1	11.2
Na ⁺ (mmol/l)	143	136	137	140	139
K ⁺ (mmol/l)	5.9	4.9	4.8	4.6	4.6
Serum albumin (mg/dl)	3.89	3.47	3.54	3.51	3.44
Serum glucose (mg/dl)	170	140	128	104	109
HbA1c (%)	8.5	NA	NA	NA	7.5
Weight (kg)	98	96	94	91	88
BMI (kg/m ²)	35.2	34.4	33.7	32.6	31.5
ECW/TBW	NA	NA	0.389	NA	0.390
Body fat mass (kg)	NA	NA	29.9	NA	25
Lean body mass (kg)	NA	NA	57.1	NA	65.1
Insulin detemir (IU/day)	36	26	20	14	10
Semaglutide (mg/week)	NA	0.25	0.5	1	1
Changes in residual renal function and dialysis parameters					
Serum creatinine (mg/dl)	6.97	6.52	7.64	8.03	9.49
CKD-EPI (ml/min)	8.48	8.6	7.22	6.75	5.51
Serum urea (mg/dl)	192	203	208	197	219
Urine creatinine (mg/dl)	43.67	42.8	46.8	58.1	52.8
Urine urea (mg/dl)	436.39	664.86	497.37	719.44	738.71
Residual diuresis (ml/24 h)	3,700	3,700	3,800	3,600	3,100
KrU (ml/min)	5.84	6.1	6.29	6.58	6.38
CrCl (ml/min/1.73 m ²)	16	15.3	14.3	14.5	13.8
GFR (ml/min/1.73 m ²)	10.9	10.7	10.3	10.5	10.1
Cr U/kg (mg/kg)	NA	16.5	18.92	22.98	18.6
U U/kg (mg/kg)	NA	256.25	201.07	284.61	260.23
Bicarbonate (mmol/l)	18.8	18.2	24.3	20	23
nPCR (g/kg/day)	NA	1.53	1.28	1.76	1.36
ACR (mg/g)	3,200	3,300	2,800	2,300	1,800
VB (l)	NA	76.7	78.7	77.33	96.86
Vinf-OL-HDF (l)	NA	26.4	26	25.3	29
KT (l)	NA	56.7	54	56	65
IDWG (kg)	NA	1	1.8	1.4	1.6
BP pre-HD (mmHg)	170/79	165/79	157/78	145/75	139/74
BP post-HD (mmHg)	193/87	182/81	172/79	163/78	155/78

ACR: albumin/creatinine ratio; BMI: Body Mass Index; BP: blood pressure; CrCl: 24 h urine creatinine clearance; Cr U/kg: urinary creatinine excretion per kilo of weight; ECW/TBW: extracellular water/total body water ratio; GFR: glomerular filtration rate; Hb: haemoglobin; Hb1Ac: glycated haemoglobin; HD: haemodialysis; IDWG: interdialytic weight gain; K⁺: plasma potassium; KrU: renal clearance of residual urea; KT: efficacy of dialysis treatment; NA: not assigned; Na⁺: plasma sodium; nPCR: normalised protein catabolic rate; U U/kg: urinary urea excretion per kilo of weight; VB: volume of blood dialysed; Vinf-OL-HDF: infusion volume in online haemodiafiltration.

There are currently few case reports describing the use of semaglutide in patients on conventional haemodialysis⁶ and, to our knowledge, there are none on incremental haemodialysis regimens. This case describes for the first time the efficacy and safety of subcutaneous semaglutide in a patient with diabetes and obesity on incremental haemodialysis with a weekly session. We describe the favourable effects on blood-glucose control, the decrease in HbA1c, blood pressure control and the preservation of residual kidney function. Despite the satiating effect of the drug, protein intake is not reduced, as shown by the normalised protein catabolic rate (nPCR) of >1 g/kg a day.

The latest Kidney Disease: Improving Global Outcomes (KDIGO) consortium clinical practice guidelines from 2020 on the management of diabetic kidney disease⁷ recommend prescribing GLP-1 RA due to their proven kidney and cardiovascular benefits, regardless of HbA1c levels. Semaglutide stimulates insulin and inhibits glucagon secretion from pancreatic islets in a glucose-dependent manner, leading to lower

serum glucose levels. This agent can therefore be expected to have the same hypoglycaemic effect in haemodialysis patients and in the general diabetic population.

In our centre, the haemodialysis regimen is adjusted according to residual kidney function, and we consider an incremental regimen with a weekly session in patients with KrU >4 ml/min/1.73 m², as well as other criteria from the DIPPI study.⁸ In the patient described here, KrU was maintained, and even improved, during the follow-up period. His glomerular filtration rate did not increase as a result of the apparent decrease in CrCl, but this was due to the increase in lean mass, which leads to an increase in serum creatinine and a decrease in its clearance. In contrast, we found an interesting increase in both urea elimination and, in particular, the excretion of creatinine per kilogram of weight. This increased excretion could be partly due to an increase in tubular secretion, which would facilitate the elimination of other substances that are at present only eliminated by

tubular secretion, such as protein-bound uraemic toxins. In addition, treatment with GLP-1 RA potentiates natriuresis, thereby improving blood pressure control. This, together with the weight loss, would explain the decrease in the albumin/creatinine ratio, which is crucial in maintaining residual kidney function.

Based on our experience, we believe that the use of GLP-1-RA in patients with diabetes and obesity helps achieve blood-glucose, weight and blood pressure control goals as well as providing other benefits on residual kidney function such as those described above. All of this would improve long-term morbidity and mortality in these patients and could facilitate their inclusion on kidney transplant waiting lists.

Ethical responsibilities

The study complied with the principles set out in the Declaration of Helsinki. The authors declare that they received the informed consent of the subject studied, and respect the patient's right to privacy. No experiments were performed on humans or animals for this study.

Conflicts of interest

The author has no conflicts of interest or financial support to declare.

REFERENCES

1. Saeedi P, Petersohn I, Salpea P, Malanda B, Karuranga S, Unwin N, et al. Global and regional diabetes prevalence estimates for 2019 and projections for 2030 and 2045: Results from the International Diabetes Federation Diabetes Atlas, 9th edition. *Diabetes Res Clin Pract* [Internet]. 2019;157. Nov 1 [Accessed 16 July 2021]. Available from: <http://www.diabetesresearchclinicalpractice.com/article/S0168822719312306/fulltext>
2. Alizic RZ, Rooney MT, Tuttle KR. Diabetic kidney disease: Challenges, progress, and possibilities. *Clin J Am Soc Nephrol* [Internet]. 2017 Dec 7;12:2032-45 [Accessed 16 July 2021]. Available from: <https://pubmed.ncbi.nlm.nih.gov/28522654/>
3. Marso SP, Bain SC, Consoli A, Eliaschewitz FG, Jódar E, Leiter LA, et al. Semaglutide and cardiovascular outcomes in patients with type 2 diabetes. *N Engl J Med* [Internet]. 2016;375:1834-44. Sep 15 [Accessed 16 July 2021]. Available from: <https://www.nejm.org/doi/full/10.1056/nejmoa1607141>
4. Alizic RZ, Cox EJ, Neumiller JJ, Tuttle KR. Incretin drugs in diabetic kidney disease: Biological mechanisms and clinical evidence. *Nat Rev Nephrol* 2020 174 [Internet]. 2020;17:227-44. Nov 20 [Accessed 16 July 2021]. Available from: <https://www.nature.com/articles/s41581-020-00367-2>
5. Kawanami D, Takashi Y. GLP-1 receptor agonists in diabetic kidney disease: From clinical outcomes to mechanisms. *Front Pharmacol*. 2020;0:967.
6. Saito S, Nakao T. Semaglutide, a newly available glucagon-like peptide receptor agonist, shows remarkable favorable effects in hemodialysis patients with obesity and Type 2 diabetes. *Ther Apher Dial*. 2021;(April):2-3.
7. de Boer IH, Caramori ML, Chan JCN, Heerspink HJL, Hurst C, Khunti K, et al. KDIGO 2020 clinical practice guideline for diabetes management in chronic kidney disease. *Kidney Int* [Internet]. 2020;98:S1-115. Oct 1 [Accessed 16 July 2021]. Available from: <http://www.kidney-international.org/article/S0085253820307183/fulltext>
8. Suárez MA, García-Cabrera E, Gascón A, López F, Torregrosa E, García GE, et al. Justificación y diseño de DiPPI: un ensayo controlado aleatorizado para evaluar la seguridad y la efectividad de la hemodiálisis progresiva en pacientes incidentes. *Nefrología*. 2018;38:630-8.

José Carlos de la Flor^{a,*}, Javier Deira^b, Tania Monzón^c, Francisco Valga^d, Cristina Albarracín^a, Elisa Ruiz^a, Miguel Rodeles^a

^a Servicio de Nefrología, Hospital central de la defensa Gómez Ulla, Madrid, Spain

^b Servicio de Nefrología, Hospital San Pedro de Alcántara, Cáceres, Spain

^c Unidad de Hemodiálisis, Avericum S.L., Las Palmas de Gran Canarias, Spain

^d Servicio de Nefrología, Hospital Universitario Dr. Negrín, Las Palmas de Gran Canarias, Spain

* Corresponding author.

E-mail address: jflomer@mde.es (J.C. de la Flor).

2013-2514/© 2021 Sociedad Española de Nefrología. Published by Elsevier España, S.L.U. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

<https://doi.org/10.1016/j.nefro.2023.08.005>