Empagliflozin and Cardiovascular and Kidney Outcomes across KDIGO Risk Categories

Post Hoc Analysis of a Randomized, Double-Blind, Placebo-Controlled, Multinational Trial

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Abstract

Background and objectives In the Empagliflozin Cardiovascular Outcome Event Trial in Type 2 Diabetes Mellitus Patients (EMPA-REG Outcome), empagliflozin, in addition to standard of care, significantly reduced risk of cardiovascular death by 38%, hospitalization for heart failure by 35%, and incident or worsening nephropathy by 39% compared with placebo in patients with type 2 diabetes and established cardiovascular disease. Using EMPA-REG Outcome data, we assessed whether the Kidney Disease Improving Global Outcomes (KDIGO) CKD classification had an influence on the treatment effect of empagliflozin.

Design, setting, participants, & measurements Patients with type 2 diabetes, established atherosclerotic cardiovascular disease, and eGFR 30 ml/min/1.73 m² at screening were randomized to receive empagliflozin 10 mg, empagliflozin 25 mg, or placebo once daily in addition to standard of care. Post hoc, we analyzed cardiovascular and kidney outcomes, and safety, using the two-dimensional KDIGO classification framework.

Results Of 6952 patients with baseline eGFR and urinary albumin-creatinine ratio values, 47%, 29%, 15%, and 8% were classified into low, moderately increased, high, and very high KDIGO risk categories, respectively. Empagliflozin showed consistent risk reductions across KDIGO categories for cardiovascular outcomes (P values for treatment by subgroup interactions ranged from 0.26 to 0.85) and kidney outcomes (P values for treatment by subgroup interactions ranged from 0.16 to 0.60). In all KDIGO risk categories, placebo and empagliflozin had similar adverse event rates, the notable exception being genital infection events, which were more common with empagliflozin for each category.

Conclusions The observed effects of empagliflozin versus placebo on cardiovascular and kidney outcomes were consistent across the KDIGO risk categories, indicating that the effect of treatment benefit of empagliflozin was unaffected by baseline CKD status.

Clinical Trial registry name and registration number: EMPA-REG OUTCOME, NCT01131676

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Introduction

CKD occurs in approximately 40% of patients with type 2 diabetes (1) and leads to a higher risk of mortality and morbidity (2,3). CKD is also a strong risk factor for cardiovascular disease (4). For example, in a large Canadian general population cohort of >900,000 individuals, the proportion of deaths from cardiovascular disease was higher with decreasing eGFR, from 28% in individuals with normal kidney function to 58% in patients with kidney failure (5). As such, treatment of CKD places a major burden on health care systems in terms of resources and costs (6,7). Therefore, there is a strong health and economic imperative to improve clinical outcomes in people with CKD and type 2 diabetes (8). Despite the introduction of novel treatment strategies for type 2 diabetes, it remains uncertain if these approaches can positively affect the course of cardiovascular and kidney disease in patients with type 2 diabetes (9).

In the Empagliflozin Cardiovascular Outcome Event Trial in Type 2 Diabetes Mellitus Patients (EMPA-REG OUTCOME), a large cardiovascular outcome study in patients with type 2 diabetes and established cardiovascular disease (10), the sodium-glucose cotransporter-2 (SGLT2) inhibitor empagliflozin significantly reduced the risk of cardiovascular death by 38%, risk of hospitalization for heart failure by 35% (10), and risk of incident or worsening nephropathy by 39%, and it decreased progression of kidney disease (11). The urinary albumin-
creatinine ratio (UACR) also improved, irrespective of baseline UACR levels, although these improvements were of greatest clinical relevance in patients with elevated baseline UACR levels (12).

The Kidney Disease Improving Global Outcomes (KDIGO) CKD classification system provides a two-dimensional framework for categorizing patients on the basis of eGFR and UACR as markers of kidney function and damage (3). These guidelines have evolved over time to include an increasingly detailed description of the relationship between GFR, albuminuria, and prognosis, which has improved our understanding of CKD in multiple populations (3). Patients with low eGFR levels and higher urinary albumin excretion rates are at higher risk of both adverse kidney and adverse cardiovascular outcomes, allowing the KDIGO CKD classification system to be adapted into a risk “heat map” as used in this analysis.

The 2012 KDIGO classification framework is a useful tool for assessing severity of kidney disease. However, it is not known whether this classification system is associated with treatment response. Here, we report a post hoc comparison of cardiovascular and kidney outcomes in participants in EMPA-REG OUTCOME using the KDIGO classification to determine the effect of baseline KDIGO risk category on treatment effect.

Materials and Methods

Study Design

EMPA-REG OUTCOME was a randomized, double-blind, placebo-controlled, multinational trial (NCT01131676; registration date May 27, 2010). Patients entered a 2-week, open-label, placebo run-in prior to randomization (1:1:1) to empagliflozin 10 mg, empagliflozin 25 mg, or placebo once daily in addition to standard of care for type 2 diabetes and cardiovascular risk management. Randomization was performed with the use of a computer-generated random sequence and interactive voice and web response system, and it was stratified according to the glycated hemoglobin (HbA1c) level at screening (<8.5% or ≥8.5%), body mass index at randomization (<30 or ≥30), kidney function at screening (eGFR of 30–59, 60–89, or ≥90 ml/min per 1.73 m²), and geographic region. Investigators were encouraged to treat cardiovascular risk factors in order to achieve optimal standard of care according to local guidelines (10,13).

The EMPA-REG OUTCOME trial was conducted in accordance with the principles of the Declaration of Helsinki and the International Conference on Harmonisation Good Clinical Practice guidelines, and it was approved by local authorities. An independent ethics committee or institutional review board approved the clinical protocol at each participating center. All of the patients provided written informed consent before study entry.

Cardiovascular outcome events and deaths were prospectively adjudicated by clinical events committees. Kidney events were reported by investigators and were not adjudicated. The trial continued until at least 691 patients experienced an adjudicated event included in the primary composite outcome: first occurrence of three-point major adverse cardiovascular event (MACE; composite of cardiovascular death, nonfatal myocardial infarction, or nonfatal stroke). Kidney function at baseline was assessed using the creatinine-based GFR estimating equations on the basis of the Modification of Diet in Renal Disease (MDRD) formula.

Participants

Eligible patients were adults with type 2 diabetes (HbA1c≤7.0% and ≤9.0% for treatment-naïve patients and HbA1c≤7.0% and ≤10.0% for patients on background glucose-lowering therapy), a body mass index of ≤45 kg/m², established cardiovascular disease, and eGFR≥30 ml/min per 1.73 m² (according to MDRD).

Outcomes and Analyses

Prespecified cardiovascular outcomes included three-point MACE and its individual components (i.e., myocardial infarction, stroke, and cardiovascular death), hospitalization for heart failure, and all-cause mortality.

Prespecified kidney outcomes have been previously described in detail and included incident or worsening nephropathy (composite of progression to macroalbuminuria, doubling of serum creatinine accompanied by eGFR of ≤45 ml/min per 1.73 m², initiation of KRT, or death from kidney disease) and progression to macroalbuminuria (11). Additionally, a post hoc analysis looked at the composite of doubling of serum creatinine, initiation of KRT, or death from kidney disease.

Cardiovascular and kidney outcomes were analyzed in subgroups by baseline KDIGO risk category (3).

Changes in eGFR values were assessed over time alongside a prespecified eGFR slope analysis for three prespecified study periods (treatment initiation effects from baseline to week 4; chronic maintenance treatment effects from week 4 to last value on treatment; and post-treatment effects from last value on treatment to follow-up) (14).

Analyses were performed in patients treated with at least one dose of study drug, and they compared the placebo and pooled empagliflozin groups. A Cox proportional hazards model was used to investigate the consistency of treatment effect on cardiovascular and kidney outcomes across subgroups. The model included terms for age, sex, baseline HbA1c category, baseline body mass index category, geographical region, treatment, baseline KDIGO risk category, and treatment by baseline KDIGO risk category interaction.

Calculation of eGFR slopes within the three prespecified study periods was performed by applying a separate random coefficient model for each period, allowing for random intercept and random slope per patient (14).

Safety data were analyzed by Poisson regression of first event using log of time at risk as offset and including factors for treatment, KDIGO risk category, and treatment by baseline KDIGO risk category interaction, yielding incidence rate ratios to assess differences between the empagliflozin and placebo groups across KDIGO risk categories.

All analyses were performed on a nominal two-sided α=0.05 without adjustment for multiplicity.

Results

The EMPA-REG OUTCOME trial has been described previously (10,13). A total of 7028 patients were randomized to study treatment from September 2010 to April 2013; 7020 patients at 590 sites in 42 countries received one or more doses of study drug (placebo, n=2333; empagliflozin
Table 1. Baseline characteristics and concomitant medications of participants were similar between treatment groups across Kidney Disease Improving Global Outcomes risk categories

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Kidney Disease Improving Global Outcomes Risk Category(^a)</th>
<th>Placebo, (n=1099)</th>
<th>Empagliflozin, (n=2223)</th>
<th>Placebo, (n=675)</th>
<th>Empagliflozin, (n=1343)</th>
<th>Placebo, (n=357)</th>
<th>Empagliflozin, (n=710)</th>
<th>Placebo, (n=186)</th>
<th>Empagliflozin, (n=359)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Age, yr</td>
<td></td>
<td>62±9</td>
<td>61±8</td>
<td>64±9</td>
<td>64±9</td>
<td>66±9</td>
<td>66±8</td>
<td>66±8</td>
<td>67±8</td>
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<tr>
<td>BMI, kg/m(^2)</td>
<td></td>
<td>30.5±5.2</td>
<td>30.5±5.2</td>
<td>31.0±5.2</td>
<td>30.7±5.3</td>
<td>30.7±5.4</td>
<td>30.6±5.3</td>
<td>30.2±5.3</td>
<td>30.6±5.7</td>
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<tr>
<td>HbA1c, %</td>
<td></td>
<td>8.0±0.8</td>
<td>8.0±0.8</td>
<td>8.1±0.9</td>
<td>8.1±0.9</td>
<td>8.2±0.9</td>
<td>8.2±0.9</td>
<td>8.2±0.9</td>
<td>8.1±0.8</td>
</tr>
<tr>
<td>Systolic BP, mm Hg</td>
<td></td>
<td>133±16</td>
<td>132±15</td>
<td>138±17</td>
<td>137±17</td>
<td>139±20</td>
<td>139±19</td>
<td>140±19</td>
<td>141±18</td>
</tr>
<tr>
<td>Diastolic BP, mm Hg</td>
<td></td>
<td>77±10</td>
<td>77±9</td>
<td>77±11</td>
<td>77±10</td>
<td>76±11</td>
<td>76±10</td>
<td>76±10</td>
<td>75±10</td>
</tr>
<tr>
<td>LDL cholesterol, mg/dl</td>
<td></td>
<td>83±34</td>
<td>85±35</td>
<td>85±34</td>
<td>85±36</td>
<td>89±39</td>
<td>88±37</td>
<td>89±39</td>
<td>90±40</td>
</tr>
<tr>
<td>eGFR (MDRD), ml/min per 1.73 m(^2)</td>
<td></td>
<td>83±16</td>
<td>84±17</td>
<td>74±20</td>
<td>74±20</td>
<td>60±19</td>
<td>61±20</td>
<td>44±8</td>
<td>43±9</td>
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<tr>
<td><strong>UACR, mg/g</strong></td>
<td></td>
<td>1.099 (100)</td>
<td>2.223 (100)</td>
<td>0.470 (70)</td>
<td>0.926 (69)</td>
<td>1.45 (41)</td>
<td>2.86 (40)</td>
<td>0</td>
<td>0</td>
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<td><strong>Smoking status</strong></td>
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<tr>
<td>Never smoked</td>
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<td>846 (77)</td>
<td>1754 (79)</td>
<td>556 (82)</td>
<td>1119 (83)</td>
<td>305 (85)</td>
<td>585 (82)</td>
<td>147 (79)</td>
<td>299 (83)</td>
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<td>Ex-smoker</td>
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<td>405 (37)</td>
<td>841 (38)</td>
<td>295 (44)</td>
<td>605 (45)</td>
<td>172 (48)</td>
<td>360 (51)</td>
<td>110 (39)</td>
<td>216 (60)</td>
</tr>
<tr>
<td><strong>Duration of diabetes, yr</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(\leq1)</td>
<td></td>
<td>95 (9)</td>
<td>181 (8)</td>
<td>77 (11)</td>
<td>146 (11)</td>
<td>48 (13)</td>
<td>84 (12)</td>
<td>23 (12)</td>
<td>50 (14)</td>
</tr>
<tr>
<td>&gt;1-5</td>
<td></td>
<td>216 (20)</td>
<td>424 (19)</td>
<td>103 (15)</td>
<td>189 (14)</td>
<td>41 (12)</td>
<td>65 (9)</td>
<td>10 (5)</td>
<td>25 (7)</td>
</tr>
<tr>
<td>&gt;5-10</td>
<td></td>
<td>301 (27)</td>
<td>597 (27)</td>
<td>159 (24)</td>
<td>344 (26)</td>
<td>69 (19)</td>
<td>156 (22)</td>
<td>35 (19)</td>
<td>64 (18)</td>
</tr>
<tr>
<td>&gt;10</td>
<td></td>
<td>547 (50)</td>
<td>1124 (51)</td>
<td>402 (60)</td>
<td>779 (58)</td>
<td>245 (69)</td>
<td>475 (67)</td>
<td>137 (74)</td>
<td>265 (74)</td>
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<tr>
<td>Metformin use</td>
<td></td>
<td>885 (61)</td>
<td>1752 (79)</td>
<td>514 (76)</td>
<td>1022 (76)</td>
<td>219 (61)</td>
<td>476 (67)</td>
<td>104 (56)</td>
<td>172 (48)</td>
</tr>
<tr>
<td>Insulin use</td>
<td></td>
<td>447 (41)</td>
<td>933 (42)</td>
<td>338 (50)</td>
<td>648 (48)</td>
<td>211 (59)</td>
<td>412 (58)</td>
<td>130 (70)</td>
<td>232 (65)</td>
</tr>
</tbody>
</table>

BMI, body mass index; HbA1c, glycated hemoglobin; MDRD, Modification of Diet in Renal Disease; UACR, urinary albumin-creatinine ratio; IQR, interquartile range; ACE, angiotensin-converting enzyme; ARB, angiotensin receptor blocker.

\(^a\)Sixty-eight patients were excluded as the subgroup variable was missing.

\(^b\)Pooled. Data are \(n\) (%) or mean ± SD unless otherwise indicated.
10 mg, \( n=2345 \); empagliflozin 25 mg, \( n=2342 \) (11). The median duration of treatment was 2.6 years (interquartile range, 1.9–3.4), and the median observation time was 3.1 years (interquartile range, 2.2–3.6); 97% of patients completed the trial.

**Baseline Characteristics**

The distribution of patients across the KDIGO risk categories is shown in Table 1. Among 7020 participants, baseline eGFR and UACR measurements were available for 6952 patients (99%; empagliflozin, \( n=4635 \); placebo, \( n=2317 \)). Baseline characteristics and concomitant medications were similar between the placebo and empagliflozin groups across the KDIGO risk categories.

The proportions of patients by KDIGO risk category in the overall study population are shown in Figure 1. As expected, randomization led to similar distributions of all patients between placebo and treatment groups within each KDIGO category (approximately 47%, 29%, 15%, and 8% in each treatment group for the low, moderately increased, high, and very high KDIGO risk categories, respectively).

**Cardiovascular Outcomes Stratified by Kidney Disease Improving Global Outcomes Risk Status at Baseline**

The event rates for all outcomes presented were higher with higher KDIGO risk category for both the empagliflozin- and placebo-treated groups (Figure 2). However, for each of the cardiovascular outcomes (three-point MACE; fatal/nonfatal myocardial infarction and fatal/nonfatal stroke cardiovascular death; hospitalization for heart failure; and all-cause mortality), the reductions in risk with empagliflozin versus placebo were consistent for patients with low, moderately increased, high, and very high KDIGO risk category at baseline (the \( P \) values for treatment by subgroup interactions across all cardiovascular outcomes ranged from 0.26 to 0.85) (Figure 2).

**Kidney Outcomes Stratified by Kidney Disease Improving Global Outcomes Risk Status at Baseline**

As observed with cardiovascular outcomes, the incidence of kidney outcome events was higher with higher KDIGO risk categories for both the empagliflozin and placebo groups (Figure 3). However, for each of the three kidney outcomes (incident or worsening nephropathy; progression to UACR >300 mg/g; and the composite of hard kidney end points [doubling of serum creatinine, initiation of KRT, or death from kidney disease]), empagliflozin was associated with a consistent and lower relative risk versus placebo across the KDIGO risk categories (the \( P \) values for treatment by subgroup interactions across all kidney outcomes ranged from 0.16 to 0.60) (Figure 3).

**Estimated Glomerular Filtration Rate Slopes**

The adjusted mean eGFR slopes for the three prespecified study periods are shown in Figure 4. Over the initial 4 weeks of treatment, the weekly mean adjusted eGFR decrease was numerically greater in the empagliflozin versus placebo groups for all KDIGO risk subgroups. During the chronic maintenance treatment period, however, the annual adjusted change in mean eGFR was stable in all empagliflozin subgroups but declined in the placebo subgroups. Finally, during the post-treatment follow-up, the adjusted mean eGFR in the empagliflozin subgroups increased, whereas little change was observed in eGFR levels in the placebo groups.
Figure 2. | Forest plot showing that the risk reduction of cardiovascular outcomes with empagliflozin versus placebo is consistent across KDIGO risk categories. *Sixty-eight patients were excluded as the subgroup variable was missing. 95% CI, 95% confidence interval; MACE, major adverse cardiovascular event; MI, myocardial infarction.
Safety

The effect of empagliflozin versus placebo on adverse events by baseline KDIGO risk category, as incidence rate ratios, is shown in Figure 5. The incidence rate ratios were similar for empagliflozin versus placebo across the adverse events assessed, with interaction P values of 0.05 for all except for the incidence of any adverse event and hyperkalemia. Except for genital infections, all incidence rates were similar or lower with empagliflozin versus placebo, indicated by the 95% confidence intervals of the incidence rate ratios below or including unity. As reported in other trials of empagliflozin and in trials of other SGLT2 inhibitors, the rates of adverse events consistent with genital infection were greater with empagliflozin than with placebo; this was seen across KDIGO risk categories (Figure 5).

Discussion

In this post hoc analysis of EMPA-REG OUTCOME, the overall numbers of cardiovascular and kidney events were higher with the degree of KDIGO risk categories in both empagliflozin and placebo groups, as reported previously in both diabetic and nondiabetic populations (15). Randomization to empagliflozin versus placebo (both given in addition to standard of care) resulted in a reduction in risk of cardiovascular outcomes (three-point MACE, cardiovascular death, hospitalization for heart failure, and all-cause mortality). This reduction in risk associated with active treatment was similar in relative terms, irrespective of baseline KDIGO risk category, and consistent with what was previously observed in the overall trial population and across patients with or without prevalent kidney disease at baseline (10,16).

In addition, empagliflozin versus placebo also lowered the risk of incident or worsening nephropathy, progression to macroalbuminuria, doubling of serum creatinine, and initiation of kidney replacement therapy, or death from kidney disease. These findings, which were seen across all baseline KDIGO risk categories, support previously reported kidney effects in the overall trial population, as well as across eGFR and albuminuria subgroups (11). The treatment effect of SGLT2 inhibitors on eGFR slopes has been shown to be a viable surrogate for clinical end points in CKD trials (17,18). The acute and chronic eGFR slopes in the EMPA-REG OUTCOME trial have previously been published (14), with similar analyses reported from the Canagliflozin Cardiovascular Assessment Study (CANVAS) and the Canagliflozin and Renal Events in Diabetes with Established Nephropathy Clinical Evaluation (CREDENCE) study (19,20). Given the acute

<table>
<thead>
<tr>
<th>Incident or worsening nephropathy</th>
<th>Empagliflozin</th>
<th>Placebo</th>
<th>Hazard ratio (95% CI)</th>
<th>Hazard ratio (95% CI)</th>
<th>P-value for interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>525/4124 (12.7)</td>
<td>388/2061 (18.8)</td>
<td>0.61 (0.53, 0.70)</td>
<td>0.60</td>
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</tr>
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<td>KDIGO risk categories*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low risk</td>
<td>78/2180 (3.6)</td>
<td>56/1086 (5.2)</td>
<td>0.67 (0.47, 0.94)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderately increased risk</td>
<td>254/1323 (19.2)</td>
<td>187/655 (28.5)</td>
<td>0.58 (0.48, 0.70)</td>
<td></td>
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</tr>
<tr>
<td>High risk</td>
<td>117/430 (27.2)</td>
<td>89/219 (40.6)</td>
<td>0.52 (0.40, 0.69)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very high risk</td>
<td>66/148 (44.6)</td>
<td>52/86 (59.1)</td>
<td>0.68 (0.47, 0.98)</td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Progression to macroalbuminuria</th>
<th>Empagliflozin</th>
<th>Placebo</th>
<th>Hazard ratio (95% CI)</th>
<th>Hazard ratio (95% CI)</th>
<th>P-value for interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>459/4091 (11.2)</td>
<td>330/2033 (16.2)</td>
<td>0.62 (0.54, 0.72)</td>
<td>0.16</td>
<td></td>
</tr>
<tr>
<td>KDIGO risk categories*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low risk</td>
<td>69/2180 (3.2)</td>
<td>39/1086 (3.6)</td>
<td>0.86 (0.58, 1.27)</td>
<td></td>
<td></td>
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<tr>
<td>Moderately increased risk</td>
<td>244/1323 (18.4)</td>
<td>179/655 (27.3)</td>
<td>0.58 (0.47, 0.70)</td>
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<td></td>
</tr>
<tr>
<td>High risk</td>
<td>94/415 (22.7)</td>
<td>75/209 (35.9)</td>
<td>0.49 (0.36, 0.66)</td>
<td></td>
<td></td>
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<tr>
<td>Very high risk</td>
<td>45/130 (34.6)</td>
<td>33/70 (47.1)</td>
<td>0.64 (0.41, 1.01)</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Doubling of serum creatinine,1</th>
<th>Placebo</th>
<th>Hazard ratio (95% CI)</th>
<th>P-value for interaction</th>
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<tbody>
<tr>
<td>All patients</td>
<td>81/4645 (1.7)</td>
<td>71/2323 (3.1)</td>
<td>0.54 (0.40, 0.75)</td>
</tr>
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<td>KDIGO risk categories*</td>
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<tr>
<td>Low risk</td>
<td>13/2205 (0.6)</td>
<td>20/1094 (1.8)</td>
<td>0.31 (0.16, 0.63)</td>
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<tr>
<td>Moderately increased risk</td>
<td>16/1334 (1.2)</td>
<td>17/671 (2.5)</td>
<td>0.46 (0.23, 0.91)</td>
</tr>
<tr>
<td>High risk</td>
<td>25/704 (3.6)</td>
<td>15/356 (4.2)</td>
<td>0.74 (0.39, 1.41)</td>
</tr>
<tr>
<td>Very high risk</td>
<td>24/352 (6.8)</td>
<td>19/186 (10.2)</td>
<td>0.64 (0.35, 1.17)</td>
</tr>
</tbody>
</table>

Figure 3. Forest plot showing that the risk reduction of kidney outcomes with empagliflozin versus placebo is consistent across KDIGO risk categories. Cox regression analysis in patients treated with one or more doses of study drug. *Sixty-eight patients were excluded as the subgroup variable was missing. †Accompanied by eGFR <45 ml/min per 1.73 m². Macroalbuminuria: urine albumin-creatinine ratio >300 mg/g.
Figure 4. Empagliflozin consistently slowed the long-term annual decline in eGFR across all patient subgroups regardless of KDIGO risk category, as assessed by mean eGFR (Modification of Diet in Renal Disease [MDRD]) slopes on the basis of random intercept/random coefficient models. Adjusted mean eGFR across subgroups of KDIGO risk category. Empa, empagliflozin.
hemodynamic effect of SGLT2 inhibitors, the treatment effect of empagliflozin on eGFR slope by baseline KDIGO risk categories was investigated. We showed that, over the initial 4 weeks of treatment, the weekly mean adjusted eGFR decrease was numerically greater in the empagliflozin versus placebo groups across all risk subgroups; however, during chronic maintenance treatment, the adjusted mean eGFR stabilized with empagliflozin but declined with placebo. In the post-treatment follow-up phase, the adjusted mean eGFR with empagliflozin returned toward mean baseline eGFR levels, whereas little change was seen with placebo.

The cardiovascular benefits in this study are also in line with more recently reported outcomes from SGLT2 inhibitor trials.

Figure 4. Continued.

Figure 5. Adverse event (AE) incidence rate ratios were similar or lower with empagliflozin compared with placebo except for genital infections. Data are from patients treated with one or more doses of study drug, including all events that occurred within 7 days after the last receipt of the study drug. Medical Dictionary for Drug Regulatory Activities version used for reporting: 18.0.
Evidence shows that the clinical presentation of CKD among adults with diabetes in the United States has evolved: low eGFR (<60 ml/min per 1.73 m²) in the absence of albuminuria (UACR<30 mg/g) is becoming the most common phenotype, with an associated higher mortality (35). Therefore, any treatment strategies will also need to address the high mortality rates associated with this trend (35).

Early detection of CKD and appropriate interventions are key to slowing disease progression and reducing the risk of adverse cardiovascular and kidney outcomes. For the small proportion of people with CKD and kidney failure who require dialysis and/or kidney transplantation, the economic effect of these interventions on healthcare budgets can be disproportionately high (3). Hence, identifying individuals at highest risk early in the disease course would enable earlier referral of those patients who will most likely gain benefit from specialist kidney services. This could lead to greater clinical and economic benefits (3). Furthermore, as CKD is a risk factor for cardiovascular disease, earlier intervention will also reduce the risk of cardiovascular and all-cause mortality. Evidence shows that the clinical presentation of CKD among adults with diabetes in the United States has evolved: low eGFR (<60 ml/min per 1.73 m²) in the absence of albuminuria (UACR<30 mg/g) is becoming the most common phenotype, with an associated higher mortality (35). Therefore, any treatment strategies will also need to address the high mortality rates associated with this trend (35).
In conclusion, the overall number of cardiovascular and kidney events was higher numerically with higher KDIGO risk categories in the empagliflozin and placebo groups. However, the observed cardiovascular and kidney benefits of empagliflozin versus placebo were consistent across KDIGO risk categories, indicating that the treatment benefit of empagliflozin was unaffected by baseline CKD status.

Disclosures

J. George reports medical writing support from Boehringer Ingelheim during the conduct of the study. He was an employee of Boehringer Ingelheim at the time of the study. S. Hantel is an employee of Boehringer Ingelheim Pharma GmbH & Co. KG. A. Kotilka-Weber reports medical writing support from Boehringer Ingelheim during the conduct of the study. She is an employee of Boehringer Ingelheim International GmbH. A. Levin reports grants, non-financial support, and other from AstraZeneca; grants, non-financial support, and other from Boehringer Ingelheim International GmbH; and grants and other from Janssen during the conduct of the study. She has also received research support from Amgen, AstraZeneca, the Canadian Institute for Health Research, the Heart and Stroke Foundation of Canada, Janssen, the Kidney Foundation of Canada, Merck, the Michael Smith Health Research Foundation, and Otsuka.

V. Perkovic is currently employed by UNSW Sydney, the Royal North Shore Hospital; reports consultancy agreements with AbbVie, Bayer, Boehringer Ingelheim, Chinchoko, GlaxoSmithKline, Janssen, and Pfizer; Astellas, AstraZeneca, Bayer, Baxter, Bristol-Myers Squibb, Durect, Eli Lilly, Gilead, GlaxoSmithKline, Janssen, Merck, Mitsubishi Tanabe, Mundipharma, Novartis, Nordisk, Pharmalink, Relypsa, Retrophin, Roche, Sanofi, Servier, and Vitae; reports research funding from Pfizer (supplied drug and seed funding for TESTING trial) and GlaxoSmithKline; reports honoraria from AbbVie, Bayer, Boehringer Ingelheim, GlaxoSmithKline, Janssen, Pfizer; Astellas, AstraZeneca, Bayer, Baxter, Bristol-Myers Squibb, Chinchoko, Durect, Eli Lilly, Gilead, GlaxoSmithKline, Janssen, Merck, Mitsubishi Tanabe, Mundipharma, Novartis, Nordisk, Pharmalink, Relypsa, Retrophin, Roche, Sanofi, Servier, and Vitae; reports serving or has served on steering committees for trials funded by AbbVie, AstraZeneca, Bayer, Boehringer Ingelheim, Chinchoko, Eli Lilly, Gilead, GlaxoSmithKline, Janssen, Merck, Mitsubishi Tanabe, Mundipharma, Novartis, Nordisk, Pharmalink, Relypsa, Retrophin, Roche, Sanofi, Servier, and Vitae; reports writing and editing for the Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group; reports serving as a board director for George Clinical, George Institute, Garvan Institute, Mindgardens Network, Childrens Cancer Institute, and Victor Chang Cardiac Research Institute. M. von Eynatten reports medical writing support from Boehringer Ingelheim during the conduct of the study. He was an employee of Boehringer Ingelheim at the time of the study. C. Wanner reports medical writing support from Boehringer Ingelheim during the conduct of the study. He also reports receiving honoraria from Boehringer Ingelheim and Janssen, outside the submitted work. D. Wheeler reports personal fees and non-financial support from AstraZeneca; and personal fees from Amgen, Boehringer Ingelheim, Bayer, GlaxoSmithKline, Janssen, MSD, Napp, Mundipharma, Pharmacosmos Reata, and Vifor Fresenius, outside the submitted work. He was a past cochair of KDIGO.

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Data Sharing Statement

The sponsor of the EMPA-REG OUTCOME trial (Boehringer Ingelheim) is committed to responsible sharing of clinical study reports, related clinical documents, and patient-level clinical study data. Researchers are invited to submit inquiries via the following website: https://trials.boehringer-ingelheim.com.

Supplemental Material

List of EMPA-REG OUTCOME investigators.

References


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