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Beyond Challenges, Towards Healthier Kidney

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Session Name : 진료지침위원회(Clinical Guidelines Committee)

Session Topic : -

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고혈압콩팥병 환자의 약물치료(Phamacologic Treatment in Hypertensive Kidney Disease)

Byung Chul Yu

Soonchunhyang University Bucheon Hospital, Republic of Korea

The primary goal of antihypertensive therapy is optimal blood pressure control, and a wide range of agents are available for clinical use. While all antihypertensive agents that lower blood pressure are believed to confer renoprotective effects, certain agents offer additional renal and/or cardioprotective benefits independent of their blood pressure-lowering properties. Based on current clinical evidence, the Clinical Practice Guideline Committee of the Korean Society of Nephrology recommend the following pharmacological strategies for patients with hypertensive kidney disease: ● In patients with albuminuria, angiotensin-converting enzyme inhibitors (ACEis) or angiotensin II receptor blockers (ARBs) are recommended as first-line agents. ● When using renin-angiotensin system (RAS) inhibitors, treatment should aim for the maximum tolerated and approved dose. ● After initiation or dose adjustment of RAS inhibitors, monitor patients within 2 to 4 weeks for symptomatic hypotension, hyperkalemia, and serum creatinine elevation. ● Combination therapy involving ACEis, ARBs, and direct renin inhibitors is discouraged due to safety concerns. ● Even without albuminuria, RAS inhibitors should be prioritized for blood pressure control in patients with chronic kidney disease (CKD). ● As second-line agents, long-acting dihydropyridine calcium channel blockers (CCBs) or diuretics may be added. In patients with signs or symptoms of fluid overload, diuretics may be preferred. ● Thiazide-like diuretics such as chlorthalidone can remain effective even when estimated glomerular filtration rate (eGFR) is below 30 mL/min/1.73 m^2. ● To achieve target blood pressure, combination therapy with RAS inhibitors, CCBs, and diuretics is recommended, preferably using a single-pill combination to improve adherence. ● In patients with resistant hypertension, mineralocorticoid receptor antagonists (MRAs) may be considered, though hyperkalemia risk rises as eGFR declines. ● For patients with hypertensive kidney disease and diabetes, non-steroidal MRAs may be considered. These recommendations emphasize a tailored approach based on individual risk

profiles and current best evidence.

Keywords: Calcium channel blockers, Diuretics, Hypertensive Kidney Disease, Pharmacological Management, Renin-angiotensin-aldosterone system inhibitor