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FINERENONE IN HEART FAILURE: PROMISE AND PRACTICALITIES FOR SOUTH ASIA

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INTRODUCTION

Heart failure not only remains a global health challenge but also puts a heavy burden in terms of lives lost and financial costs on the health system. This burden is cumbersome in South Asia. The region is dealing with an increasing trend of cardiovascular risk factors like diabetes, hypertension, ischemic heart disease, and chronic kidney disease (CKD). These conditions not only increase the risk of heart failure but also increase the progression and make it difficult to manage.

The treatment options for heart failure with preserved ejection fraction (HFpEF) have increased over the past few years, but for heart failure with reduced ejection fraction (HFrEF), treatment strategies have remained limited. This is where the finerenone, a nonsteroidal mineralocorticoid receptor antagonist (MRA), being a newer drug in its class, comes into play. But, the question arises whether it is truly better than what we already have, and most importantly, can it be realistically used in our settings?

WHERE ARE WE WITH MRAS?

We have known for years that MRAs save lives in HFrEF. Spironolactone and eplerenone, both steroidal MRAs, were game changers in their time. The RALES and EMPHASIS-HF trials showed they could reduce hospitalizations and death [1,2]. But they are not perfect.

Many patients, especially those with CKD, develop hyperkalemia, a common problem in our region. Spironolactone comes with hormonal side effects like gynecomastia, which can affect adherence. And when it comes to HFpEF, the TOPCAT trial gave us mixed signals, with benefit seen only in certain regions[3]. So while MRAs are effective, their real-world use, especially in South Asia, is often limited by safety concerns and patient tolerability.

WHAT IS DIFFERENT ABOUT FINERENONE?

Finerenone is part of a new class, a non-steroidal MRA. It is more selective in how it blocks the mineralocorticoid receptor. It has a more balanced distribution across the tissues. The hope is that this makes it safer, especially for people with chronic kidney disease.

And the data so far looks promising. In FIDELIO-DKD and FIGARO-DKD trials, finerenone significantly reduced the risk of cardiovascular events and slowed kidney disease progression in people with type 2 diabetes and CKD [4,5]. The FIDELITY pooled analysis confirmed these benefits across a larger population[6].

More recently, the FINEARTS-HF trial looked at people with heart failure with preserved or mildly reduced ejection fraction (LVEF $\geq$40%), a group that had limited treatment options. Finerenone reduced hospitalizations and cardiovascular death [7]. And more importantly, the risk of hyperkalemia was lower than we would expect with traditional MRAs.

WHY THIS MATTERS FOR SOUTH ASIA

In our region, the intersection of diabetes, CKD, and HFpEF is the norm. That makes finerenone particularly interesting for clinicians in South Asia.

What makes it attractive is better safety in CKD. Many of our patients can not tolerate spironolactone due to an increased risk of hyperkalemia. Finerenone could help keep them on therapy longer. We finally have a potential tool for a patient group that has been hard to treat. The cardiovascular and renal benefits are hard to ignore, especially in patients with diabetes.

But there are hurdles, like the cost. Let's be honest, the finerenone is an expensive drug. In a region where spironolactone is

available for a few rupees, cost is a serious barrier. No direct comparisons—we don't yet have head-to-head trials between finerenone and spironolactone, making it hard to know how beneficial it is. Guideline uncertainty is not yet firmly embedded in heart failure guidelines for people without diabetes or CKD, which leaves clinicians unsure.

Conclusion

What needs to happen next is to move forward responsibly with finerenone in South Asia; we will need more than just excitement. We will need evidence and a strategy.

Local data from South Asian countries to see how finerenone performs outside clinical trials, especially in public sector hospitals. Health systems need clear data to justify paying more for this drug. If it reduces hospitalizations, that could help offset the higher price, but we need the math to prove it.

References:

1. Pitt B, Zannad F, Remme WJ, Cody R, Castaigne A, Perez A, et al. The effect of spironolactone on morbidity and mortality in patients with severe heart failure. N Engl J Med. 1999;341(10):709–717.
2. Zannad F, McMurray JJ, Krum H, van Veldhuisen DJ, Swedberg K, Shi H, et al. Eplerenone in patients with systolic heart failure and mild symptoms. N Engl J Med. 2011;364(1):11–21.
3. Pitt B, Pfeffer MA, Assmann SF, Boineau R, Anand IS, Claggett B, et al. Spironolactone for heart failure with preserved ejection fraction. N Engl J Med. 2014;370(15):1383–1392.
4. Bakris GL, Agarwal R, Anker SD, Pitt B, Ruilope LM, Rossing P, et al. Effect of finerenone on chronic kidney disease outcomes in type 2 diabetes. N Engl J Med. 2020;383:2219–2229.
5. Pitt B, Filippatos G, Agarwal R, Anker SD, Bakris GL, Rossing P, et al. Cardiovascular events with finerenone in kidney disease and type 2 diabetes. N Engl J Med. 2021;385:2252–2263.
6. Filippatos G, Anker SD, Agarwal R, Pitt B, Ruilope LM, Rossing P, et al. Finerenone and cardiovascular outcomes in patients with chronic kidney disease and type 2 diabetes: the FIDELITY pooled analysis. Eur Heart J. 2022;43(6):474–484.
7. FINEARTS-HF Investigators. Finerenone in heart failure with preserved ejection fraction. Presented at: ESC Congress 2023; August 25–28, 2023; Amsterdam, Netherlands.