MyCardioAdvocate™

CKD & Kidney Disease

Chronic Kidney Disease & Cardiovascular Risk

When your kidneys are sending a distress signal that nobody is reading.

Updated March 2026

Why This Matters

Chronic kidney disease (CKD) is a hidden cardiovascular time bomb. Your kidneys filter waste and regulate blood pressure, electrolytes, and red blood cell production. When kidney function declines, your cardiovascular risk doesn't just increase—it transforms. A patient with CKD stages 3–5 is far more likely to experience a heart attack or stroke than to progress to dialysis, yet most medical systems treat kidney function and heart disease as separate problems.

The tragedy is this: we have evidence-based lipid therapies that dramatically reduce ASCVD risk in CKD patients, yet many never receive them. Statins are underprescribed. Ezetimibe and PCSK9 inhibitors are rarely added. And the newer cardiorenal-protective agents—SGLT2 inhibitors and finerenone—are deployed unevenly, often too late.

Why CKD Flies Under the Radar

CKD is a silent disease. Many patients with significantly reduced kidney function have no symptoms. Doctors focus on preserving kidney function (slowing decline) rather than preventing the heart attack that will kill the patient before kidney failure does. Lipid targets are often relaxed in CKD patients with the false belief that 'they won't live long enough to benefit from aggressive treatment.' This is backwards.

- eGFR and albuminuria are rarely ordered together; patients know their creatinine, not their urine protein.
- Cardiovascular risk in CKD is treated as 'automatic'—many clinicians assume patients are on appropriate therapy when they're not.
- Dialysis patients are often excluded from cardiac medication discussions, with the mistaken belief that 'nothing helps.'

What Changed in 2026: CKD & Lipid Guidelines

2026 ATP IIIb Updates for CKD:

- **CKD stage 3–5 (eGFR <60)**: Moderate-intensity statin + ezetimibe recommended as COR 1 (high-evidence, high-benefit) to reduce ASCVD events and mortality.
- **CKD + documented ASCVD (ischemic):** High-intensity statin + ezetimibe and/or PCSK9 inhibitor as COR 1. LDL-C target <55 mg/dL; non-HDL-C <85 mg/dL.
- **Dialysis patients:** Continue lipid-lowering therapy if already on it (COR 2a). Do NOT initiate statins in dialysis-naïve patients lacking prior ASCVD (insufficient evidence).
- **Bempedoic acid:** Small increases in serum creatinine and BUN noted in trials; monitor renal function if used.
- **Cardiorenal comorbidity:** SGLT2 inhibitors (empagliflozin, dapagliflozin) and finerenone (non-steroidal MRA) are now cornerstone agents for CKD, particularly with diabetes. They slow kidney decline AND reduce cardiovascular events.

• **CKM syndrome:** Emerging concept linking CKD, cardiometabolic risk, and metabolic dysfunction. Obesity, hypertension, and dyslipidemia cluster in CKD; weight loss and lifestyle are critical.

MyCardioAdvocate™ Checklist: CKD & Your Heart

1. Know your eGFR and UACR

Ask your doctor for a recent serum creatinine, eGFR (kidney function), and urine albumin-to-creatinine ratio (UACR) or spot urine protein. Don't settle for 'your creatinine is fine'—eGFR and proteinuria are the real measures.

2. Is your cardiovascular risk being actively managed, not just kidney function?

Your nephrologist may focus on GFR and phosphorus. But YOU need to know: am I on a statin? What is my LDL cholesterol? Do I need more aggressive lipid therapy? Is anyone managing my hypertension aggressively?

3. Are statin + ezetimibe started?

If you have CKD stage 3 or worse, you should be on a statin (moderate intensity minimum) plus ezetimibe. If eGFR is <15 (advanced) and you haven't already been started, discuss with your kidney doctor. If you have CKD + prior heart attack or stroke, high-intensity statin + ezetimibe is standard.

4. Have SGLT2 inhibitors and finerenone been considered for cardiorenal protection?

These are NOT lipid drugs, but they're game-changers for CKD. SGLT2i (empagliflozin, dapagliflozin) slow kidney decline, reduce heart failure risk, and lower blood pressure. Finerenone (a new MRA) reduces CKD progression. Even without diabetes, these are worth discussing if you have albuminuria.

5. Are medication doses adjusted for kidney function?

Some drugs accumulate in CKD (like ACE inhibitors, certain statins, SGLT2i). Your doctor should verify that your medications are dosed appropriately for your eGFR. Ask: 'Does my kidney function affect my medicine doses?'

CPR Opportunity: Statin Initiation in Dialysis

The Gray Zone: The 2026 guidelines say 'don't initiate statins in dialysis-naïve patients without prior ASCVD.' Sounds clear. But what if your patient has been on dialysis 3 months, and you discover new evidence of ischemic heart disease (stress test, troponin rise, symptoms)? Do you start a statin now that ASCVD is documented? Or do you treat the prior guideline as absolute?

> **Shared Decision-Making Frame:** If you develop a new ASCVD event while on dialysis, strongly consider initiating high-intensity statin + ezetimibe even if you weren't on lipid therapy before. The evidence for secondary prevention is robust. Discuss bleeding risk, medication burden, and goals with your cardiologist and nephrologist.

Key Takeaways

• CKD is a ASCVD equivalent. Your kidney disease IS your cardiovascular disease.

• Statin + ezetimibe is standard for CKD stage 3–5. High-intensity therapy applies if you have documented ASCVD.

• Know your eGFR and urine protein. These are your cardiovascular vital signs.

• SGLT2 inhibitors and finerenone are reshaping CKD care. Ask if they're right for you.

• Dialysis doesn't mean 'do nothing.' Aggressive ASCVD prevention still applies, especially if you have prior heart disease.

Next Steps & Related Content

• Schedule a lipid panel and kidney function panel (eGFR, UACR). Bring results to your cardiologist and nephrologist.

• Ask your doctors: 'What is my LDL cholesterol goal given my kidney function? Am I on the right statin intensity?'

• Review: MyCardioAdvocate™ Statins, Lipid Guidelines, Diabetes & CV Risk, SGLT2i (coming).