Atrial Fibrillation

An emerging burden

and the promise of finerenone



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What would finerenone add?

A clinical decision to revisit at the end

68

year-old man

Paroxysmal AF
HFpEF, LVEF 55%
Previous HF admission

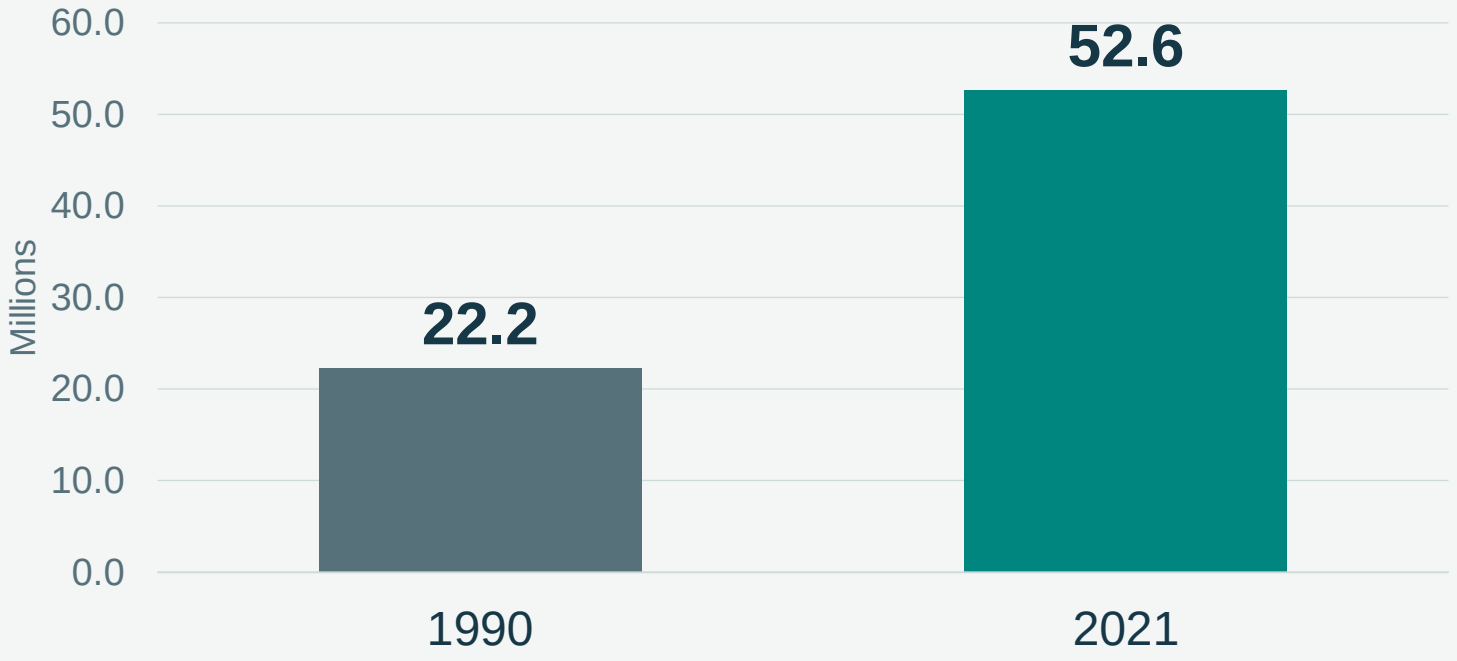
T2D with albuminuric CKD
eGFR 42 UACR 220 mg/g K^+ 4.4 mmol/L

On apixaban, maximum tolerated losartan and an SGLT2 inhibitor

Fewer HF events? Fewer AF recurrences? Both?

The global AF burden has more than doubled

People living with AF or atrial flutter, GBD 2021 estimates



+137%

in absolute numbers

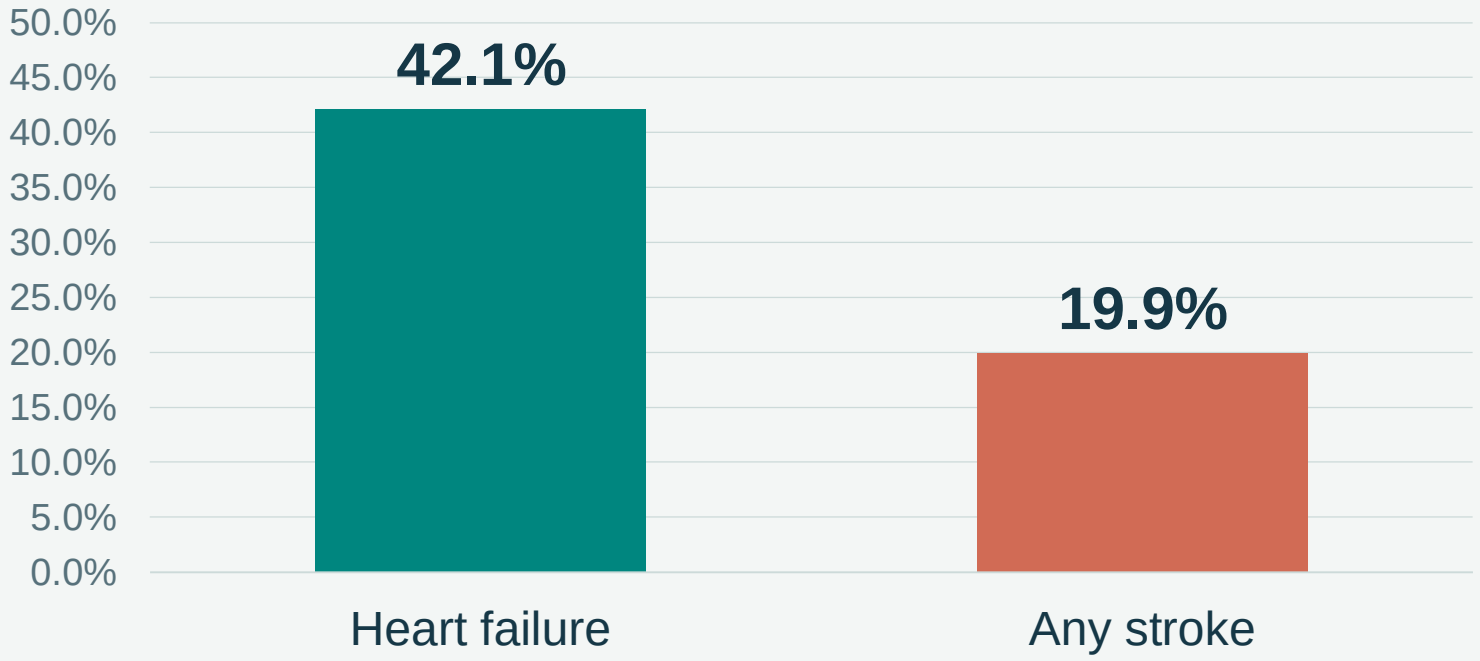
Age-standardised prevalence remained broadly stable.

Population growth and ageing drive a larger clinical workload.

Cheng et al. Europace 2024. Same GBD model for both years.

Heart failure is central to the AF burden

Lifetime risk after AF, contemporary Danish population



≈1 in 3

Lifetime risk of AF from age 45

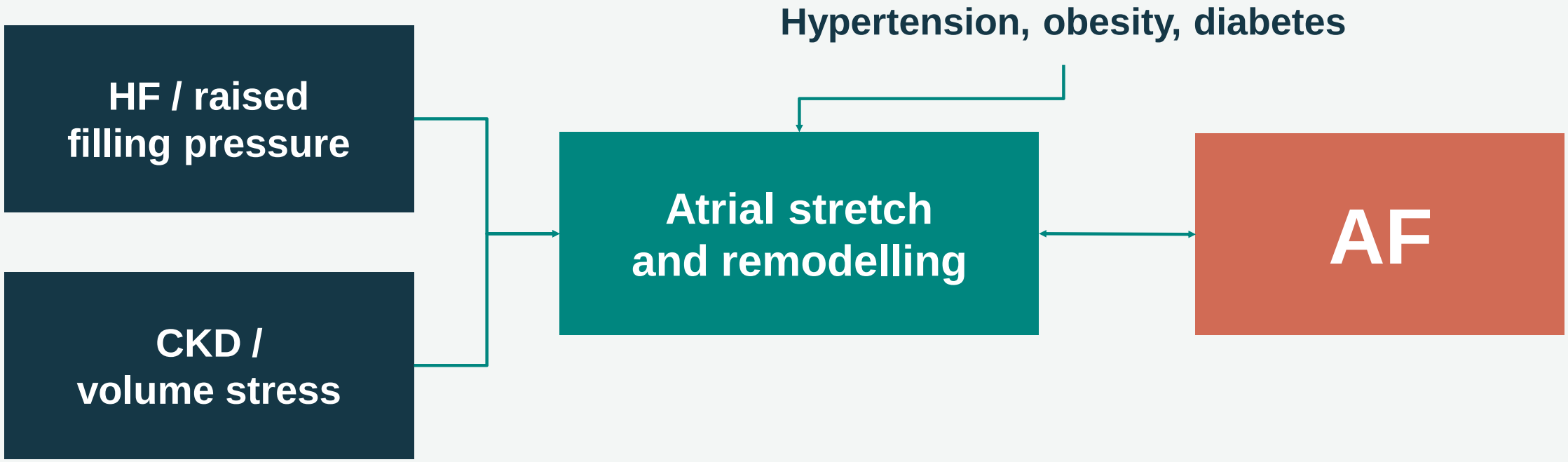
30.9% in this Danish cohort
Not a universal population estimate

Stroke prevention remains essential. HF prevention also matters.

Vinter et al. BMJ 2024. Denmark, 2011–2022, index age 45, follow-up to age 95.

AF sits within a shared disease substrate

Cardiac, kidney and metabolic disease reinforce atrial vulnerability



An AF consultation is also an opportunity to treat cardiorenal disease.

2024 ESC AF guideline. Conceptual relationship diagram, not a causal effect estimate.

AF-CARE puts comorbidity treatment first

C **Comorbidities and risk factors**

A Avoid stroke and thromboembolism

R Reduce symptoms with rate and rhythm control

E Evaluation and dynamic reassessment

Finerenone belongs under C when a cardiorenal indication exists.

Van Gelder et al. 2024 ESC Guidelines for AF.

MR signalling offers a plausible target

A biological rationale for prevention



Human AF prevention must be demonstrated in clinical data.

Lavall et al. J Biol Chem 2014; Biochem Pharmacol 2019. Mechanism shown schematically.

Three randomized trials anchor the program

Finerenone versus placebo on background care

Trial	Population	Primary outcome
FIDELIO-DKD 5,674 analyzed	T2D + albuminuric CKD	Kidney failure / ≥40% eGFR decline / renal death
FIGARO-DKD 7,352 analyzed	T2D + broader CKD spectrum	CV death / MI / stroke / HF hospitalization
FINEARTS-HF 6,001 analyzed	Symptomatic HF LVEF ≥40%	Total worsening HF events + CV death

The main trials tested organ outcomes. AF analyses ask an additional question.

Bakris et al. NEJM 2020; Pitt et al. NEJM 2021; Solomon et al. NEJM 2024.

FIDELITY established cardiorenal benefit

13,026 participants with T2D and CKD, median follow-up 3.0 years

Cardiovascular composite

0.86

HR 95% CI 0.78–0.95

12.7% vs 14.4%

CV death, nonfatal MI/stroke, HF hospitalization

Event proportions: finerenone vs placebo

Kidney composite

0.77

HR 95% CI 0.67–0.88

5.5% vs 7.1%

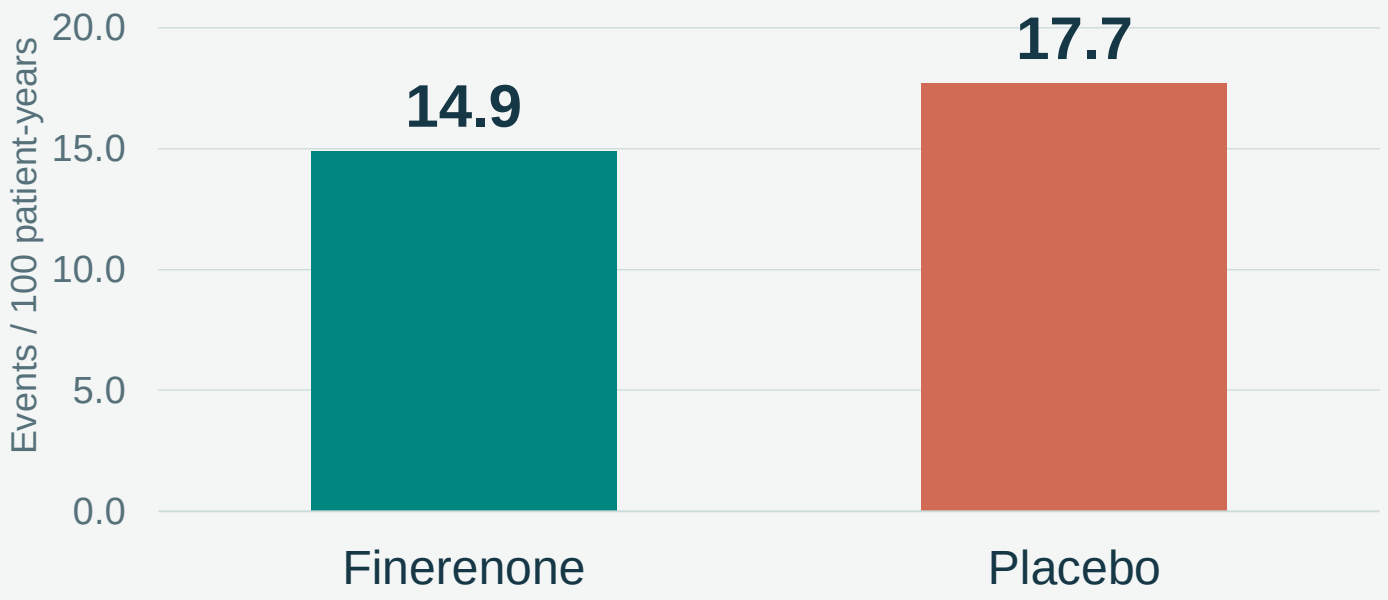
Kidney failure, ≥57% eGFR decline, renal death

Pooled FIDELIO + FIGARO data, not another independent randomized trial.

Agarwal et al. Eur Heart J 2022. Finerenone versus placebo.

FINEARTS-HF reduced worsening HF events

6,001 patients with symptomatic HF and LVEF ≥40%, median 32 months



0.84

Rate ratio
95% CI 0.74–0.95
P = .007

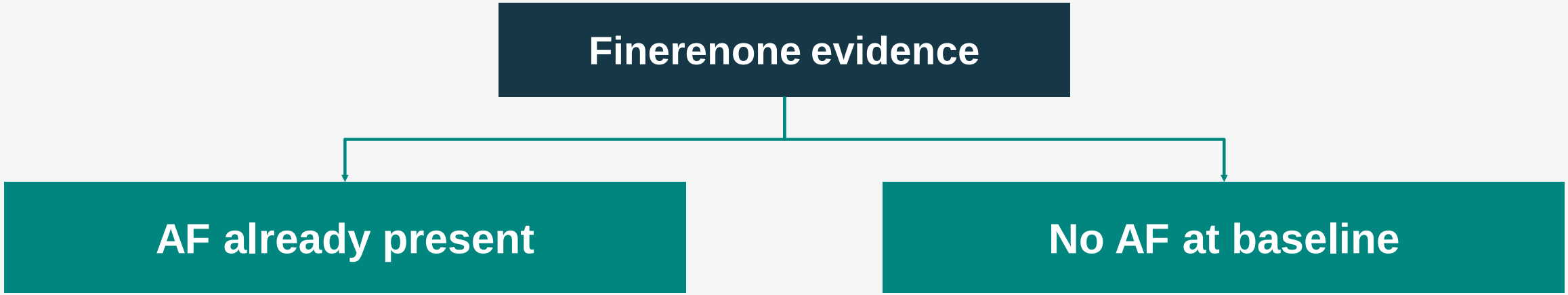
CV death alone
HR 0.93 (0.78–1.11)

The composite benefit was driven by fewer worsening HF events.

Solomon et al. NEJM 2024. Total first/recurrent HF events plus CV death.

Existing AF and first AF are different endpoints

Both matter, but the evidence answers different clinical questions



Does finerenone reduce HF events?

FINEARTS-HF subgroup analysis

Does finerenone reduce first detected AF/AFL?

Incident AF/AFL analyses

Matsumoto et al. JAMA Cardiol 2025; Pabon et al. JACC 2025.

HF benefit was consistent across AF groups

FINEARTS-HF: total worsening HF events + cardiovascular death

Baseline AF group	Participants	Rate ratio (95% CI)
No AF	2,714	0.80 (0.65–0.98)
Paroxysmal AF	1,384	0.83 (0.65–1.06)
Persistent / permanent AF	1,886	0.85 (0.69–1.05)

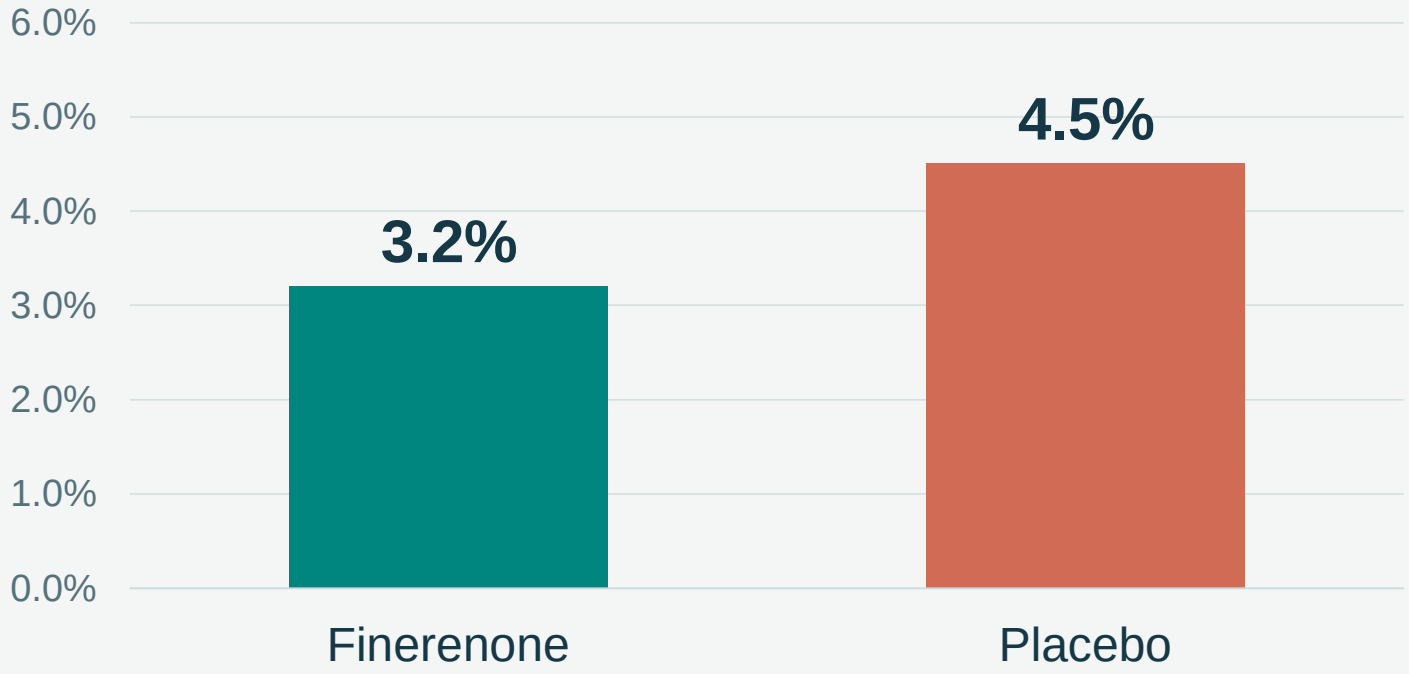
This is evidence about HF outcomes, not AF recurrence.

AF status did not identify a group with a different HF treatment effect.

Matsumoto et al. JAMA Cardiol 2025. Interaction P = .94.

FIDELIO-DKD gave the first AF signal

New-onset AF/AFL in participants without a history of AF/AFL



0.71

Hazard ratio
95% CI 0.53–0.94
P = .016

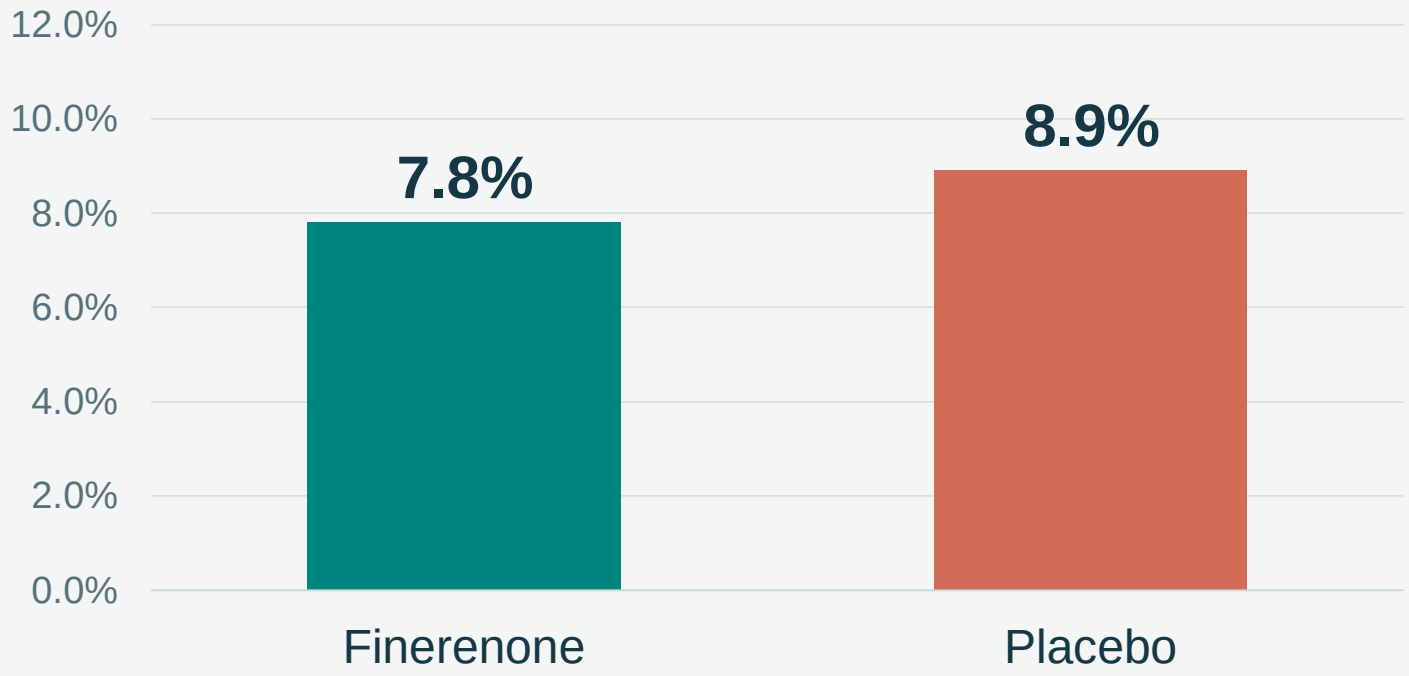
82 vs 117 participants with first AF/AFL

A prespecified exploratory analysis in diabetic CKD.

Filippatos et al. JACC 2021. Original FIDELIO AF analysis.

FINEARTS alone left AF prevention uncertain

New-onset AF/AFL: 3-year cumulative incidence



0.77

Subhazard ratio
95% CI 0.57–1.04
P = .09

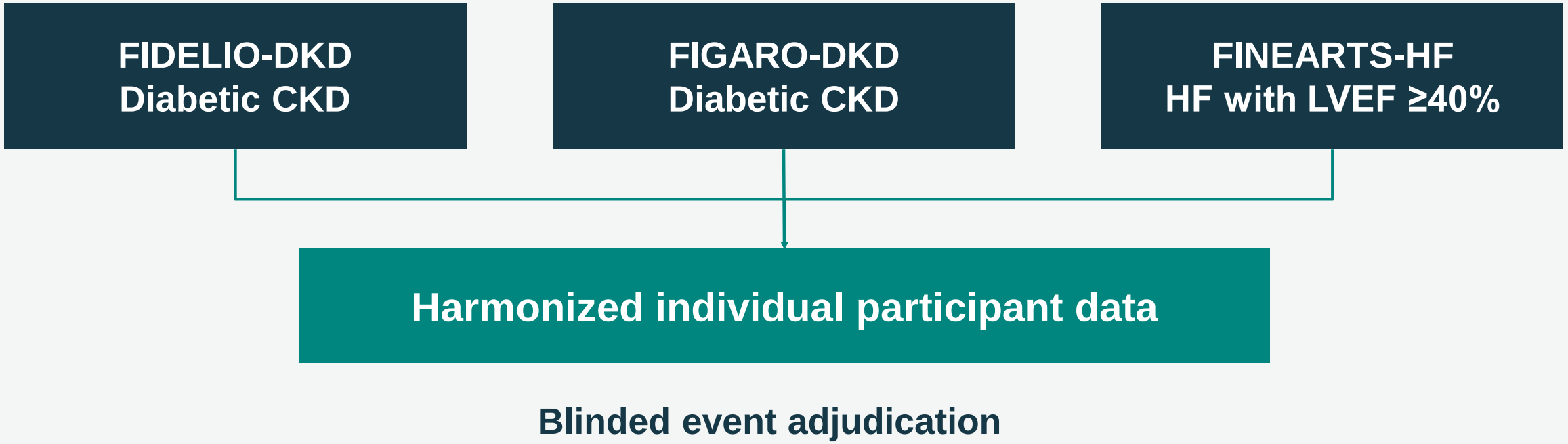
175 new AF/AFL events across both groups

The confidence interval includes no effect.

Matsumoto et al. JAMA Cardiol 2025. Competing-risk analysis.

FINE-HEART pooled the randomized evidence

Prespecified participant-level analysis of incident AF/AFL

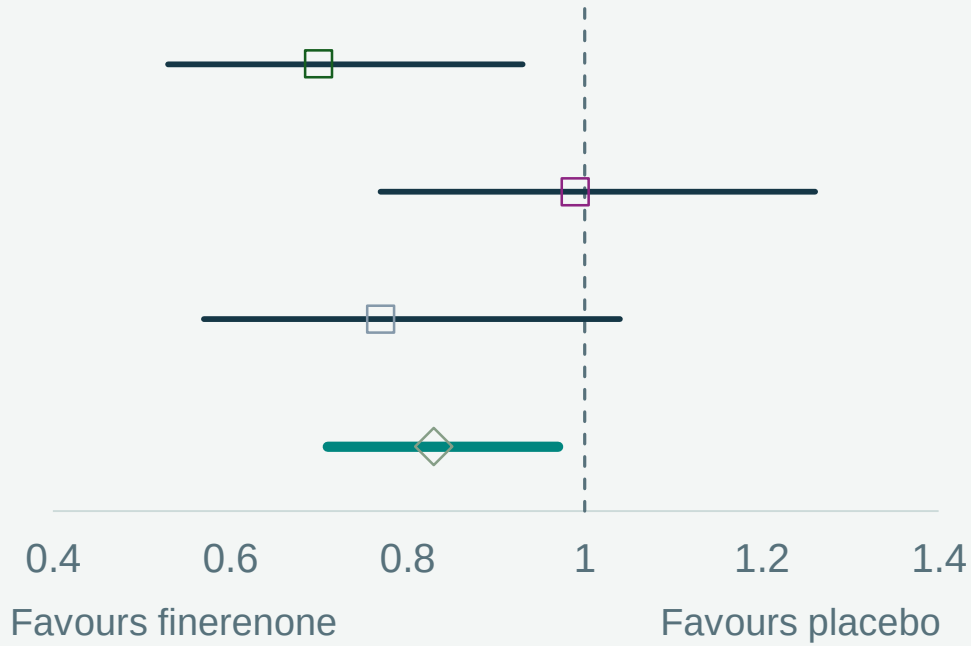


14,581 participants without AF/AFL at baseline

Pabon et al. JACC 2025. AF/AFL was a prespecified secondary pooled outcome.

The pooled AF estimate favours finerenone

First detected AF/AFL, harmonized FINE-HEART analysis

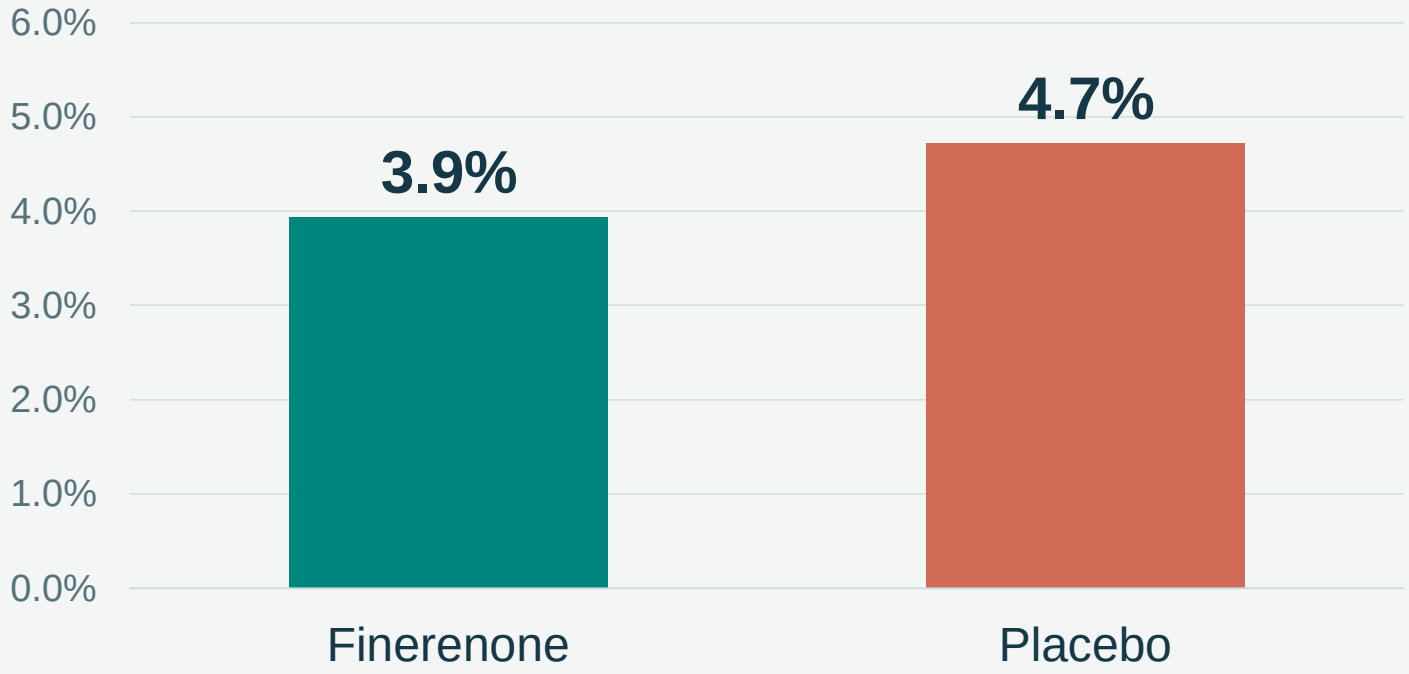


Pooled HR 0.83 (95% CI 0.71–0.97), P = .019

Pabon et al. JACC 2025. Component rows are not independent of the pooled row.

The absolute AF difference is modest

FINE-HEART, median follow-up 2.9 years



≈8

fewer first AF/AFL cases per 1,000

Observed difference ≈0.8 percentage points
286 / 7,267 vs 345 / 7,314

First-AF prevention may add to established cardiorenal benefit.

Pabon et al. JACC 2025. Crude observed proportions, not fixed-time risks.

The AF evidence has clear boundaries

What the evidence supports	What remains unproven
Fewer detected first AF/AFL events in pooled CKM trial populations	Lower AF recurrence or burden in patients with established AF
HF benefit despite baseline AF	Human atrial fibrosis reversal as the mechanism of benefit
A plausible preventive contribution within cardiorenal treatment	An AF-only prescribing indication or superiority over other MRAs

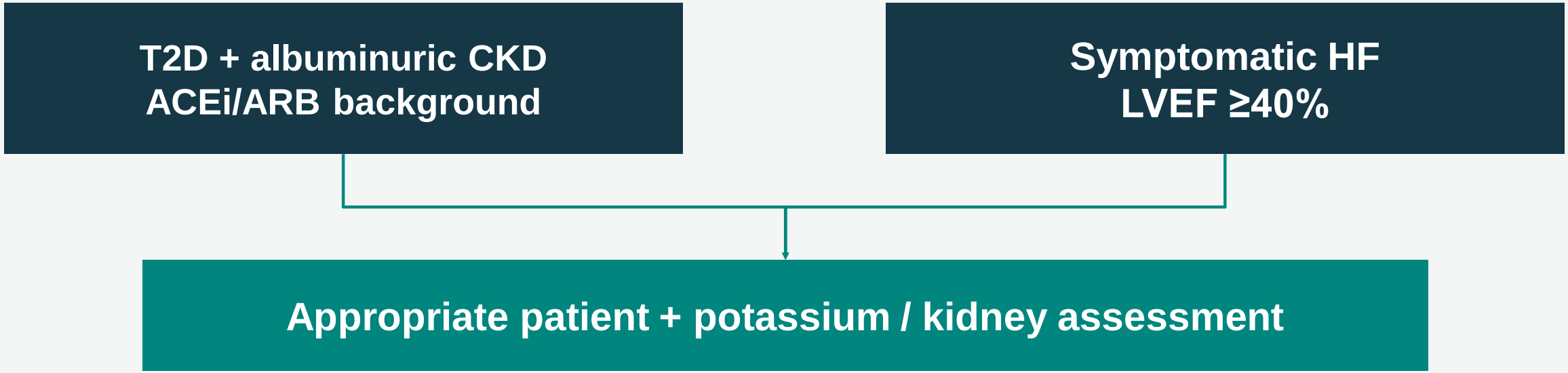
AF/AFL was not a primary trial endpoint. No prolonged rhythm monitoring.

Incident AF reduction does not establish treatment of existing AF.

FINE-HEART and FINEARTS AF analyses. Finerenone has no AF-specific indication in reviewed US/EU labels.

Clinical use starts with a valid indication

AF strengthens the reason for comprehensive care



AF alone is insufficient as a prescribing indication.

AF care continues alongside cardiorenal treatment.

US FDA label, July 2025; EMA SmPC, May 2026. Confirm current local product authorization.

Potassium monitoring is part of the treatment

Before starting

Potassium and eGFR

Do not initiate if K^+ >5.0 mmol/L
or eGFR <25 mL/min/1.73 m^2

Medication review

Strong CYP3A4 inhibitors are contraindicated
Avoid another MRA / potassium-sparing diuretic

9.7% vs 4.2%

Reported hyperkalemia
finerenone vs placebo

0.4% vs 0.2%

Hyperkalemia-related
permanent discontinuation

Baseline, 4 weeks, after dose changes, then periodically.

FDA prescribing information 2025; EMA SmPC 2026. Hyperkalemia figures from FINEARTS-HF.

This patient merits cardiorenal protection

The 68-year-old man with AF, HFpEF and albuminuric diabetic CKD

Reasonable expectation

Fewer worsening HF events and benefit for eligible diabetic CKD

What we cannot promise

Fewer AF recurrences or freedom from AF

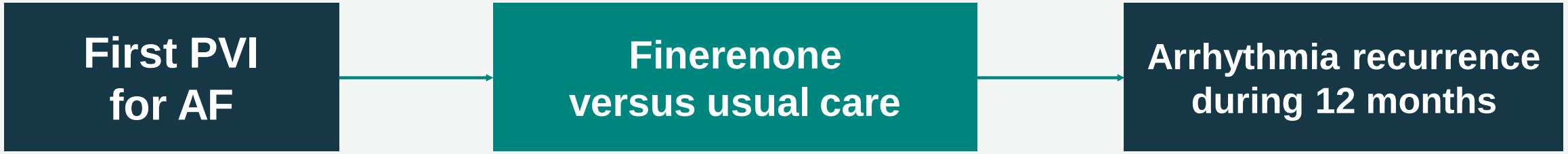
Practical plan

Confirm local indication, interactions and follow-up potassium/eGFR

“I would discuss finerenone for cardiorenal protection, with monitoring.”

The next question is AF recurrence

FINE-CA pilot: finerenone after first catheter ablation



Planned N = 40

Phase 2 pilot
90-day blanking period

Recruiting. No results. This remains a research question.

ClinicalTrials.gov NCT07799519, first posted 2 September 2026. Status checked 26 September 2026.

The promise of finerenone in AF care

AF is a growing cardiorenal problem.

Finerenone has established organ benefits and a modest signal for first AF prevention.

Patient selection and potassium monitoring turn evidence into useful care.

Key references: burden and cardiorenal outcomes

AF burden and clinical framework

Cheng et al. Europace 2024;26:euae195
Vinter et al. BMJ 2024;385:e077209
Van Gelder et al. Eur Heart J 2024;45:3314–3414

Finerenone pivotal and pooled trials

Bakris et al. NEJM 2020;383:2219–2229
Pitt et al. NEJM 2021;385:2252–2263
Agarwal et al. Eur Heart J 2022;43:474–484
Solomon et al. NEJM 2024;391:1475–1485

Key references: AF analyses and prescribing

AF-specific randomized evidence

Filippatos et al. JACC 2021;78:142–152
Matsumoto et al. JAMA Cardiol 2025;10:696–707
Pabon et al. JACC 2025;85:1649–1660

Clinical use and future research

FDA prescribing information, July 2025
EMA product information, May 2026
FINE-CA, ClinicalTrials.gov NCT07799519

Finerenone dosing depends on the indication

Once daily. US/EU labeling shown. Confirm current local product approval.

Baseline eGFR	Starting dose	CKD + T2D target	HF ≥40% target
≥60	20 mg	20 mg	40 mg
25 to <60	10 mg	20 mg	20 mg
<25	Do not initiate	—	—

eGFR units: mL/min/1.73 m². Do not initiate if K^+ >5.0 mmol/L.

K^+ and eGFR reassessment at 4 weeks guides titration.

FDA July 2025 and EMA May 2026. Follow the full indication-specific potassium algorithm.

Primary trial endpoints and effect estimates

Trial	Primary endpoint	Result
FIDELIO-DKD	Kidney failure, sustained ≥40% eGFR decline, renal death	HR 0.82 (0.73–0.93) 17.8% vs 21.1%
FIGARO-DKD	CV death, nonfatal MI/stroke, HF hospitalization	HR 0.87 (0.76–0.98) 12.4% vs 14.2%
FINEARTS-HF	Total worsening HF events and CV death	RR 0.84 (0.74–0.95) 1,083 vs 1,283 events

Finerenone versus placebo. HR = hazard ratio. RR = rate ratio.

Bakris et al. NEJM 2020; Pitt et al. NEJM 2021; Solomon et al. NEJM 2024.

Incident AF/AFL: harmonized pooled data

Study	Finerenone	Placebo	HR (95% CI)
FIDELIO-DKD	82 / 2,576	117 / 2,611	0.70 (0.53–0.93)
FIGARO-DKD	128 / 3,344	129 / 3,336	0.99 (0.77–1.26)
FINEARTS-HF	76 / 1,347	99 / 1,367	0.77 (0.57–1.04)
FINE-HEART	286 / 7,267	345 / 7,314	0.83 (0.71–0.97)

Pooled median follow-up 2.9 years. Trial interaction P = .57.

Pabon et al. JACC 2025. Numbers are participants with first AF/AFL / randomized group.

Questions likely to arise

Can it replace spironolactone in every HF patient?

No. The trials shown do not establish head-to-head superiority or replacement across all HF phenotypes.

Can it reduce AF recurrence or justify stopping anticoagulation?

Recurrence benefit remains unproven. Anticoagulation decisions follow thromboembolic risk and AF guidance.

Does less incident AF prove reversal of atrial fibrosis?

No. Mechanistic plausibility and observed clinical prevention do not establish the causal pathway.