The Untapped Potential of the ADPKD Treatment Landscape

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Background:

Autosomal dominant polycystic kidney disease (ADPKD) is identified by nephrologists as one of the top three renal conditions with the highest unmet need for new treatment options. Tolvaptan is currently the only FDA-approved treatment that is available for ADPKD, underscoring a significant opportunity for new entrants to foster market growth.

Methodology:

Data was collected in January 2024 in partnership with 101 US nephrologists via an online survey.

Acknowledgements:

Thank you to Spherix Global Insights' network of nephrologists and their patients.

Disclosures:

Ellie McClatchy, Bridget Bergan, and Jennifer LaFave are employees of Spherix Global Insights, an independent market intelligence firm and have received no industry funding to conduct and report on this study.

Figure 1

Statement Agreement
% of respondents

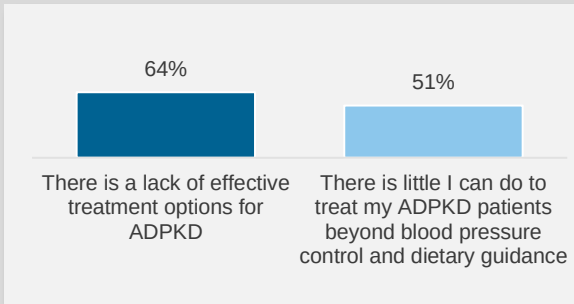


Figure 2

Tolvaptan Use
% of respondents

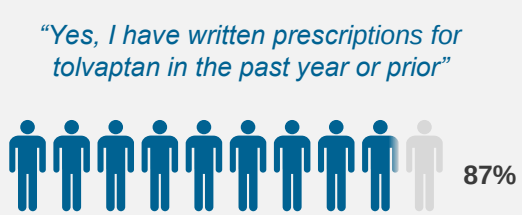


Figure 3

Substantial Barriers to Enrolling Patients in the Tolvaptan REMS Program
% of respondents

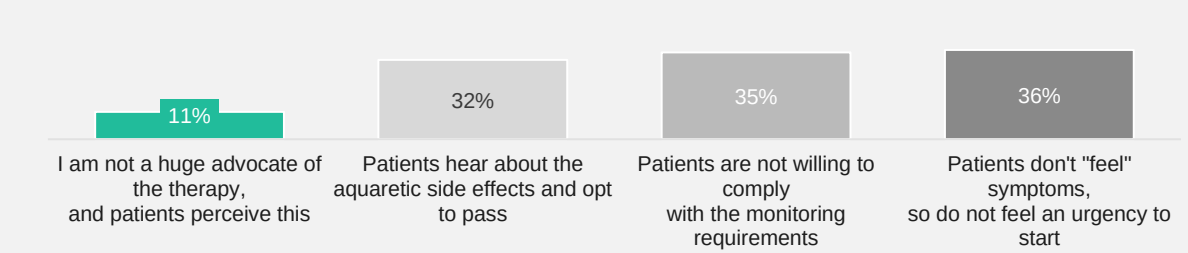


Figure 4

Low Familiarity with Pipeline Agents for ADPKD
% of respondents

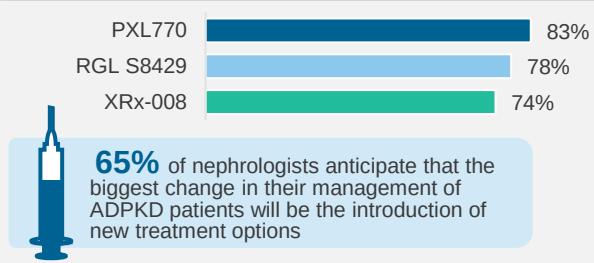
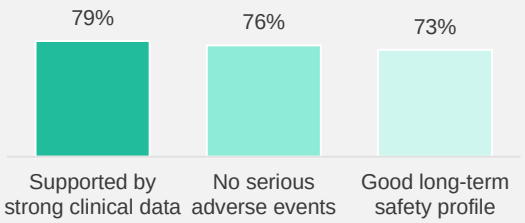


Figure 5

Top 3 Factors For Selecting ADPKD Treatment
% of respondents ranking "extremely important"



Results:

Despite the availability of tolvaptan, two-thirds of nephrologists agree that there is a lack of effective treatment options for ADPKD (64%), and half believe that there is little they can do to treat these patients beyond blood pressure control and dietary guidance (51%) (Fig. 1). Current treatment regimens include ACE inhibitors/ARBs, fluid intake of at least three liters per day, SGLT2 inhibitors, and tolvaptan.

Nearly all nephrologists (87%) report that they have prescribed tolvaptan to at least one of their ADPKD patients (Fig. 2) and express that the REMS program is not a barrier to their use of the drug. However, they also report that they encounter patient resistance to starting therapy with tolvaptan, especially since the most ideal patients often present as asymptomatic, are unable to tolerate the required water intake, and may be hesitant to begin a long-term treatment regimen that has monitoring requirements (Fig. 3). Nephrologists report that 17% of their ADPKD patients are currently being treated with tolvaptan and just under one-third (32%) of users report being highly satisfied with the drug.

Looking forward, nearly two-thirds of nephrologists anticipate that the biggest change in their management of ADPKD patients will be the introduction of new treatment options. Although their awareness of pipeline agents for ADPKD is low (Fig. 4), physicians primarily seek new agents that effectively slow the progression of eGFR decline with no serious adverse events, good long-term safety profiles, and are supported by both clinical and outcomes data (Fig. 5).

Conclusions:

As new agents for ADPKD advance in their clinical trials, physician education on efficacy and safety data will be key in helping to drive the evolution of ADPKD treatment where significant unmet needs remain.

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