

Recommendations by the Asian Pacific society of nephrology (APSN) on the appropriate use of HIF-PH inhibitors.

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approach for renal anaemia management. Despite it being approved for clinical use in various Asia-Pacific countries, its novelty mandates the need for nephrologists and clinicians generally in the region to well understand potential benefits and harms when prescribing this class of drug. The Asian Pacific society of nephrology HIF-PHI Recommendation Committee, formed by a panel of 11 nephrologists from the Asia-Pacific region who have clinical experience or have been investigators in HIF-PHI studies, reviewed and deliberated on the clinical and preclinical data concerning HIF-PHI. This recommendation summarizes the consensus views of the committee regarding the use of HIF-PHI, taking into account both available data and expert opinion in areas where evidence remains scarce.

The Asian Pacific society of nephrology HIF-PHI Recommendation Committee summarizes the consensus views of the committee regarding the use of HIF-PHI, taking into account both available data and expert opinion in areas where evidence remains scarce.

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Hypoxia inducible factor (HIF) is a key transcription factor primarily involved in the cellular regulation and efficiency of oxygen delivery. Its preliminary state comprises a constitutively expressed, nucleus-bound β -subunit and three isoforms of a cytoplasmic α -subunit (HIF-1 α , HIF-2 α and HIF-3 α). HIF-1 α and HIF-2 α are master regulators of defensive mechanisms against hypoxia and enhance oxygen delivery by stimulating a variety of genes. Representative target genes are erythropoietin (EPO) and those that optimize iron utilization.

When oxygen availability is normal, the α -subunit is sequentially degraded: first by prolyl hydroxylation by HIF-prolyl hydroxylase (HIF-PH), followed by ubiquitination via the Von Hippel Lindau (VHL) gene and the E3 ubiquitin ligase complex, which facilitates proteosomal degradation. However, prolyl hydroxylation is oxygen-dependent; hence, during periods of hypoxia HIF-PH loses its activity, resulting in stabilization of the α -subunit before it undergoes nuclear translocation and formation of a heterodimer with the β -subunit. As the oxygen sensing mechanism and the adaptive response against hypoxia is so important and essential, three great scientists who elucidated this mechanism, Peter Ratcliffe, Gregg Semenza, and William Kaelin Jr., were awarded the Nobel Prize in Physiology and Medicine in 2019.

The current standard-of-care treatments for anaemia in chronic kidney disease (CKD) is intravenous (IV) or subcutaneous (SC) administration of human recombinant EPO or its derivatives, known as erythropoiesis stimulating agents (ESA) which stimulate the haematopoietic system specifically. HIF-PH inhibitors (HIF-PHI) are now approved and available in some countries as an oral drug of a completely new mechanism to treat anaemia in CKD. 1, 2, 3, 4 HIF-PHI work systemically and may exert some effects outside the haematopoietic system. Being a relatively novel therapy that was first approved in various Asia-Pacific countries, it is important for nephrologists and clinicians within the region to well understand the potential benefits and harms when prescribing this class of drug. Based on these backgrounds, the Asian Pacific Society of Nephrology HIF-PHI Recommendation Committee, formed by a panel of 11 nephrologists who have clinical experience or been investigators in HIF-PHI studies, reviewed and deliberated on the current clinical and pre-clinical evidence regarding HIF-PHI. This Recommendation summarizes the consensus views of the Committee regarding the use of HIF-PHI, taking into account both the available data and expert opinion in areas where evidence remains to be sought, and will be further

updated when new clinical data emerges in the future.

<Recommendation> Physicians can consider HIF-PHI as alternatives to ESA in correcting and maintaining haemoglobin level for renal anaemia both in dialysis-dependent and non-dialysis-dependent CKD patients based on the new data concerning its efficacy and safety.

Physician can consider HIF-PHI as alternatives to ESAs in correcting and maintaining haemoglobin (Hb) for renal anaemia both in dialysis-dependent (DD) and non-dialysis-dependent (NDD) CKD patients based on the new data concerning its efficacy and safety from several recent clinical trials. 5, 6 These trials show that the efficacy and safety of HIF-PHI are comparable to ESAs in treating renal anaemia in the short term, although the long-term risks and benefits of HIF-PHIs in treating renal anaemia remains to be assessed.

Physicians should recognize that HIF-PHI are very different in its mechanism of action of erythropoiesis compared to ESAs. ESAs stimulate erythropoiesis by acting specifically on the erythropoietin receptor that expressed on red blood cell precursors. 6, 7 HIF-PHI not only enhances erythropoietin production but also exerts other on-target effects through many genes under the HIF pathway in all cells. These on-target effects are influenced by pharmacokinetic/pharmacodynamic properties, dosing intervals and the selectivity of each inhibitor against the three different HIF-PH enzymes. 7 Thus, physicians should also appreciate that small molecular compounds of HIF-PHI are likely to have some off-target activities against structurally related enzymes because HIF-PH enzymes are a part of a large enzyme superfamily with many important functions.

Physicians should understand the pharmacologic profiles (Table 1) of each HIF-PHI based on clinical trial data, 8, 9, 10, 11, 12, 13, 14 initiate HIF-PHI at an appropriate dose, and adjust HIF-PHI to achieve the Hb target stipulated in the guidelines of each country.

Pharmacologic profiles of HIF-PHIs in phase III development *

Shown are the most commonly used dosing regimens reported in phase II/III studies.

Abbreviations: BCRP, breast cancer resistance protein; BIW, Bi-weekly; CYP, cytochrome P456; CYP, cytochrome P450; DD, dialysis-dependent CKD; DMET, drug metabolic enzymes and transporters; HD, haemodialysis; n.r., not reported/not published; ND, non-dialysis-dependent CKD; OAT, organic anion transporter; OATP, organic anion transporting polypeptides; PD, peritoneal dialysis; QD, once daily; QOD, alternative daily; QW, once weekly; TIW, thrice weekly; UDP, uridine 5'-diphosphate; UGT, UDP-glucuronosyltransferase.

<Recommendation> Iron status should be evaluated before HIF-PHI are used. We suggest correcting iron deficiency before initiation of HIF-PHI (ferritin > 100 ng/mL and TSAT > 20%) for all CKD patients.

The iron status should be evaluated before HIF-PHI is commenced. Serum ferritin and transferrin saturation (TSAT) are used to assess iron status, and ferritin levels <100 ng/mL [< 200 ng/mL in haemodialysis (HD) patients] or TSAT<20% are considered as iron deficiency. During induction phase of HIF-PHI treatment (about 8 weeks), reduced TSAT occurs because of increased transferrin levels (total iron binding capacity, TIBC) and may not indicate iron deficiency. The optimal ferritin and TSAT levels in the maintenance phase of HIF-PHI treatment remain undefined, and in this context we suggest ferritin levels of no less than 100 ng/mL and TSAT no less than 20% (opinion).

Iron deficiency should be corrected before initiation of HIF-PHI (ferritin>100 ng/mL and TSAT>20%) for all CKD patients. For NDD patients, we suggest using oral iron for those who require iron supplementation. For DD patients, we suggest oral iron to be tried first and IV iron be

considered an alternative for those who do not tolerate oral iron or when the physician opines that IV iron is necessary.

Preclinical and clinical studies have shown that HIF-PHI activation is associated with enhanced intestinal iron absorption and increased availability of iron for erythropoiesis. 15, 16, 17, 18, 19 Clinical trials showed that less IV iron was required in HIF-PHI arm compared with ESA arm in DD patients. 20 Phase 2 and 3 trials in China showed that the effect of roxadustat was not dependent on IV iron in both NDD and DD patients. 21, 22 In clinical studies, HIF-PHIs have been shown to increase blood TIBC with no significant changes in serum iron levels, resulting in reduced TSAT. 23 Treatment with HIF-PHI is also associated with decreased blood ferritin level and hepcidin level. 24, 25 Iron deficiency is associated with thromboembolic events, and clinical trials of roxadustat in Japan have reported increased incidence of thromboembolic events. 26 As treatment with HIF-PHIs may decrease serum iron levels due to increased availability of iron for erythropoiesis, one should pay attention to avoid treatment-induced reduction in serum iron levels.

<Recommendation> Anaemia in CKD should be controlled using ESAs or HIF-PHI after sufficient iron supplementation.

If patients with good drug adherence desire oral treatment because of various reasons such as frequency of hospital visits and invasiveness of injections in case of non-HD patients, HIF-PHI may be preferable than ESAs. In case of treatment with HIF-PHI, an issue of polypharmacy should be acceptable.

If target Hb cannot be achieved with the recommended dose of ESA, the priority is to search for the cause of ESA hyporesponsiveness and consultation with a nephrologist/specialized medical institution should be considered. If the cause of ESA hyporesponsiveness is unknown or difficult to manage due to defective iron utilization or some other reasons, conversion to HIF-PHI should be considered.

Anaemia in CKD stage G3 ~ 5 or G5T patients can be managed with ESAs or HIF-PHI after sufficient iron supplementation. If patients with good drug adherence desire oral treatment because of various reasons such as frequency of hospital visits and invasiveness of injections, HIF-PHI may be preferable than ESAs. In case of treatment with HIF-PHI, an issue of polypharmacy should be acceptable.

Patient should be screened for malignant tumour and retinal lesions before the use of HIF-PHI. HIF-PHI can be commenced when confirmed that there are no such complications or that appropriate treatment has been provided. It is advisable to avoid the use of HIF-PHI when the above medical conditions are poorly controlled as the long-term safety data are lacking. The use of HIF-PHI should be exercised with caution in patients with pre-existing ischemic heart disease, cerebrovascular disease or peripheral vascular disease (obstructive arteriosclerosis and deep vein thrombosis) because of the concerns of thromboembolic complications. The size of renal cysts should also be followed when HIF-PHI is used in patients with polycystic kidney disease, as acceleration of cysts expansions by HIF-PHI has been observed in animal studies.

If the target Hb cannot be achieved with the recommended dose of ESA, the priority is to search for the cause of ESA hyporesponsiveness and consider consultation with a nephrologist/specialized medical institution. If the cause of ESA hyporesponsiveness is unknown or difficult to manage due to defective iron utilization or some other reasons, conversion to HIF-PHI should be considered.

Anaemia in CKD stage G5D patients should be managed with ESA or HIF-PHI after adequate iron supplementation. In patients receiving peritoneal dialysis (PD), HIF-PHI may be preferred to ESA especially in those with good drug compliance and desire oral therapy to minimize the frequency of hospital visits and avoid parenteral drug administration. As in CKD G3 ~ 5 or G5T patients, an issue of polypharmacy should be acceptable.

The concerns and precautions for malignancy, retinal tumour, thromboembolic events and cyst growth (in patients with polycystic kidney disease) are similar to that in CKD G3–5 or G5T patients. Acquired cystic disease of the kidney in DD patients is prone to develop malignancy, and one should monitor for the development of tumour in patients with acquired cystic disease of the kidney treated with HIF-PHI.

As in CKD G3 ~ 5 or G5T patients, clinicians should first investigate for the cause of ESA hyporesponsiveness and consider consulting a dialysis specialist/specialized medical institution if the Hb level cannot be achieved with the recommended dose of ESA. Conversion to HIF-PHI should be considered if the cause of ESA hyporesponsiveness is unknown or difficult to manage due to defective iron utilization or some other reasons.

<Recommendation> Before prescribing HIF-PHI, the presence and risk of malignancy should be ascertained and, in patients with known malignancy, administration should be undertaken only with great caution—if at all. Given the theoretical and experimental concerns associated with sustained increased HIF activity, as well as evidence of the long-term malignancy risk posed by related genetic diseases, it will be essential to maintain post-marketing cancer surveillance for at least 5 years.

Apart from increasing EPO transcription and inhibiting hepcidin production, HIF also induces transcription of genes relating to neo-vascularization and tumour growth (specific to tumour type). These include vascular endothelial growth factor (VEGF), nitric oxide, TWIST gene, metalloproteinase and mitogen-activated protein kinase, among others. Importantly, HIF-1 α (rather than HIF-2 α) appears related to tumour gene activity and associated with metastatic spread for breast, prostate, lung, bone and colorectal cancers. 27 Nonetheless, HIF-2 α has also been identified in in vitro malignant hepatocellular lines, is involved in the activation of cancer stem cells factor and is strongly associated with various tumour metastases, as well as a poor prognosis. 28 , 29

The relevance of HIF activation on the potential for malignancy is evident in conditions such as VHL disease, where the incidence of several tumours, including renal cell carcinoma (RCC) is increased. Conversely, most RCCs display somatic mutations in the VHL gene, reducing proteolysis of the HIF α -subunit and increasing HIF activity. 30 Solid tumours have a poorer prognosis when HIF activity is increased 31 and trials examining the clinical effect of HIF inhibitors on RCCs are underway.

Given the association between HIF and tumour progression, emergence of the HIF-PHI forces us to consider whether stimulating HIF transcription might also raise the risk of initiating or progressing tumour growth.

There are five different agents that are currently in or have recently completed Phase 3 studies: daprodustat, roxadustat, vadadustat, molidustat and enarodustat. Newer agents in development include desidustat (ZYAN1), which has recently completed a Phase 2 study in Australia, and JNJ-429045343, which is in pre-clinical development. Of these, roxadustat is approved for clinical use in Japan and China, and daprodustat and vadadustat are approved for clinical use in Japan. Additional applications relating to other compounds are pending. Although there is a recognised class effect, insofar as each agent selectively inhibits the prolyl hydroxylase (PHD) enzymes with reductions in serum hepcidin and ferritin and shares a similar cardiovascular profile, each has a distinct molecular structure, half-life, adverse event profile and probably PHD selectivity. 32 Molidustat for instance primarily inhibits PHD 2, and daprodustat PHD 2 and PHD 3, whereas roxadustat appears to inhibit all three PHDs. Whether such selectivity will influence malignancy risk for individual PHIs remains to be seen.

Despite the theoretical potential for oncogenesis for any and all the PHIs, there is minimal evidence to date of such concerns—and of note that none of the phase 3 trials have been ceased by the relevant data monitoring committee. If this safety profile proves to be sustained, reasons could

relate to the dominant role of HIF-1 α in tumour development and progression and the relative selectivity (particularly HIF-2 α) of the PHIs. Another possibility is the apparently small effect of PHIs on HIF activity: no trial has demonstrated detectable changes in serum VEGF and all have indicated only marginal increases in serum EPO concentrations. The latter is in contrast to findings from the TREAT study, where a marked increase in deaths from cancer was suggested in association with administration of the erythropoietic stimulating agent, darbepoetin. 33

At least two agents have been assessed regarding their potential for cancer development in longer-term murine studies: roxadustat and daprodustat. 34, 35 Roxadustat is usually administered to humans at doses up to 1.5 mg/kg daily or thrice-weekly (TIW). At doses of up to 10 (rats) and 60 (mice) mg/kg administered TIW and followed for up to 104 weeks, there was no effect in either animal on survival or on the development of neoplastic lesions. 34 Similarly, daprodustat was administered to a cohort of mice and Sprague-Dawley rats for up to 2 years at ≥ 143 -fold the predicted maximal human clinical exposure. Again, no neoplastic changes were observed, although (male) rat lifespan was curtailed due erythrocytosis, aortic thrombosis and/or associated cardiomyopathy.

In summary, from the available animal and short-term human data, so far there is no evidence of tumour risk with the use of PHIs. Whether the same can be said for humans, and whether there is a difference between primary oncogenesis and enhancing known tumour growth and spread is unclear. Some idea of the relative risk of malignancy will be available following publication of current studies, but since patients with known tumours were unlikely to be enrolled, it is probable such questions will not be fully addressed. Given broad marketing approval ensues, or in Japan maintained, it will be essential to maintain post-marketing surveillance for a substantive period—at least 5 years—given the theoretical and experimental concerns associated with increased HIF activity, as well as the long-term malignancy risk posed by related genetic diseases.

<Recommendation> Retinopathy is a theoretical concern of HIF-PHI in CKD patients. Early referral for ophthalmologic assessment is warranted in patients who report visual disturbance after drug initiation.

Retinopathy is a sight-threatening condition and remains a serious concern in the use of HIF-stabilizer in CKD patients. Theoretically, activation of the HIF pathway may enhance retinal angiogenesis and predispose patients to retinal complications such as haemorrhage. 36 The overall incidence of retinal adverse events is low. While the current data suggest that HIF-PHI is not associated with increased risk of retinal haemorrhage compared with ESA, one should appreciate that patients with high propensity for retinal complications were excluded from clinical trials of HIF-PHI published. 14, 21, 22, 23, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51 Furthermore, duration of these clinical trials may have been too short or too small to observe aggravation of retinal adverse events. It is important to have high alertness if patient reports visual disturbance after initiation of HIF-PHI and early referral for ophthalmologic assessment is warranted.

<Recommendation> Liver dysfunction is relatively uncommon in CKD patients receiving HIF-PHI. Regular monitoring of liver function may facilitate early detection of HIF-PHI related hepatic dysfunction.

The effect of HIF on liver and hepatic diseases remains elusive. Animal data suggest that HIF confers protective effect on ischaemic-reperfusion injury of liver but shows pathogenic roles in the progression of hepatic fibrosis and fatty liver. 52 In an open-label randomized study in dialysis patients, transient elevation of liver biochemistries was noted in two roxadustat-treated patients (3.3%) during the 12-week treatment period and both showed normalization of liver function without drug discontinuation. 20 In a phase 3 study of roxadustat in Chinese patients receiving dialysis, two subjects (1%) showed liver dysfunction which was mild or moderate in severity. 37 The derangement in liver function test, however, was not observed in another phase 3 study of roxadustat conducted in NDD Chinese CKD patients. 22 Liver dysfunction was also not reported in

phase 2 or 3 studies of other HIF-PHI including desidustat, enarodustat, molidustat and vadadustat. 14, 42, 43, 44, 45, 46, 51, 53 While the incidence of hepatic abnormalities is low, regular monitoring of liver function may help facilitate early detection of HIF-PHI-related hepatic dysfunction.

<Recommendation> The data on hyperkalemia as an adverse effect of HIF-PHI is inconclusive. However, considering hyperkalemia can be a medical emergency, we suggest serum potassium being monitored in patients receiving HIF-PHI treatment.

Among the 25 published randomized controlled trials (RCTs) that evaluate the efficacy of HIF-PHI on renal anaemia, 14, 21, 22, 23, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51 nine have reported hyperkalemia (Table 2, and Table 3). Six of these studies reported a higher incidence rate of hyperkalaemia among patients treated with HIF-PHI while the other three studies have reported increased rates of hyperkalaemia in the control arm. For NDD patients, hyperkalemia was reported as a TEAE (>5% events) in 4 of the 12 clinical studies. Three of the four roxadustat RCTs reported higher incidence rates of hyperkalemia [26/250 (10%) vs 6/109 (5.5%) in roxdustat and control groups respectively]. 21, 22, 23, 38 One of two RCTs of vadadustat reported increased incidence of hyperkalemia [7/138 (5%) vs 0/72 (0%) in vadadustat and control arms respectively]. 42 While the phase 3 study in China reported higher rate of hyperkalemia in roxadustat arm, there was no difference in hyperkalemia between roxadustat and the placebo groups when data from the central laboratory was used for analysis. As for DD patients, five out of the 13 RCTs reported hyperkalemia. Three of the four roxadustat studies reported higher rates of hyperkalemia [16/386 (4.1%) vs 3/158 (1.8%) in roxadustat and control groups respectively]. 21, 37, 47, 54 Two of the five daprodustat studies reported increased incidence rates of hyperkalemia [8/239 (3.3%) vs 1/59 (1.6%) in daprodustat and control groups, respectively]. 40, 41, 48, 49, 50 As in NDD patients, the rates of hyperkalemia were comparable between roxadustat and control groups when the central laboratory data were used for analysis. Taken together, although higher rates of hyperkalemia have been reported in the HIF-PHI arm in some studies, the data so far remain inconclusive. Considering that hyperkalemia can be a life-threatening complication, we suggest that serum potassium being monitored after the initiation of HIF-PHI and regularly during the treatment.

Hyperkalemia in non-dialysis-dependent population

Hyperkalemia in dialysis-dependent population

<Recommendation> Clinical studies have no signals that suggest a hypertensive effect of HIF-PHI, but as ESA use is associated with hypertension or compromised blood pressure control, one should pay attention to blood pressure control in patients treated with HIF-PHI.

It is well recognized that the administration of ESA is associated with development of hypertension and compromised blood pressure control. Therefore, the effect of HIF-PHI on blood pressure has been a valid concern. While some pre-clinical data have suggested that HIF-PHIs may have anti-hypertensive effect, clinical studies so far also have no signals that suggest hypertensive effect of HIF-PHI 14, 21, 22, 23, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51 (Table 4 and Table 5) Furthermore, there is by far no studies that specifically examines the effect of HIF-PHI on blood pressure in humans.

Hypertension in non-dialysis-dependent population

Hypertension in dialysis-dependent population

<Recommendation> Clinical studies have no signals that suggest aggravation of pulmonary hypertension or heart failure by HIF-PHI, but one should pay attention to changes of cardiac function in patients treated with HIF-PHI.

Pulmonary hypertension and heart failure are common cardiovascular complications among CKD patients. It was reported that pulmonary hypertension and heart failure were present in 30%–40% and 40%–59% of patients with CKD respectively, 55, 56, 57 and the prevalence increases with the more advanced stages of CKD.

Studies on genetic HIF activation, for example, Chuvash polycythaemia, which is caused by homozygous mutation of VHL, reported that severe pulmonary hypertension may occur in this hypoxia sensing disorder. 58, 59 Studies using viable heterozygous HIF-2 α -deficient mice after exposure to hypoxia showed protection against pulmonary hypertension and right ventricular hypertrophy in HIF-2 α -deficient mice, unveiling a critical role of HIF-2 α in hypoxia-induced pulmonary vascular remodelling. 60 HIF-2 α was shown to mediate upregulation of vasoconstrictors which contribute to the development of hypoxic pulmonary vascular remodelling. Further, inactivation of Phd2 in endothelial cells resulted in severe pulmonary hypertension, abnormal muscularization of peripheral pulmonary arteries, and right ventricular hypertrophy. 61 Concurrent inactivation of either Hif1a or Hif2a in endothelial cell-specific Phd2 mutants demonstrated that the development of pulmonary hypertension was dependent on HIF-2 α but not HIF-1 α . Persistent HIF activation may cause more intense vasoconstrictive effect to hypoxia at pulmonary vasculatures leading to increased pulmonary pressure. The potential adverse effect of aggravating pulmonary hypertension by HIF-PHIs, however, has not been reported in recently published RCTs. 22, 37

Correction of renal anaemia has been shown to reduce incidence of heart failure and improve cardiac function. However, there were a series of reports on reduced cardiac function following sustained activation of HIF or inhibition of prolyl hydroxylase. 62, 63, 64, 65 Studies of HIF deletion in a model of heart failure reported discrepant results. 66, 67 The molecular mechanism of this effect is not clearly defined. Basic science studies suggested that this might be associated with the extent of HIF activation, where over-activation of HIF might lead to defective energy utilisation of the cardiac myocytes. This highlights the importance of the fine balance between prolyl hydroxylase inhibition to stimulate erythropoiesis for correction of renal anaemia and modest HIF activation at the heart to prevent deterioration of cardiac function. One should also pay attention to the experimental study which showed that HIF-1 directly up-regulated BNP, a marker of heart failure. 67 The potential benefits of HIF-PHIs on improving myocardial ischaemia and the potential risks of compromising cardiac function need to be further studied in RCTs.

<Recommendation> Clinical data and basic studies raise the concerns of thrombotic events in HIF-PHI treatment. We suggest a limited use of HIF-PH inhibitors in patients with any history of thrombotic events or a careful use of HIF-PHI in patients with cardiovascular disease. Large studies with unbiased reports and long-term follow-up are required.

Previous studies have demonstrated that treatment of anaemia in CKD by ESAs increases Hb levels, reduce transfusion requirements and improves quality of life. 33, 68, 69 However, treatment to high Hb targets with large doses of ESA has resulted in increased rates of vascular access thrombosis, cerebrovascular events, cardiovascular events and mortality. 70, 71 Patients with mutations in genes such as VHL, EGLN1 (encoding PHD2), EPAS1 (encoding HIF2 α), and the EPO receptor can result in polycythemia and vascular complications such as cerebral vascular events and peripheral thromboembolism. 72, 73 The lessons from ESA trials and patients with HIF pathway mutations imply the thrombotic risk of HIF-PH inhibitor treatment. Whether this is an issue in patients with reasonable Hb target and with low risk of cardiovascular disease at enrollment is not clear.

Basic studies have shown that HIF pathway is associated with thrombosis and plaque stability. In this context, hypoxia and HIF target genes modulate coagulation, fibrinolysis, and thrombus resolution. HIF increases tissue factor expression and triggers thrombus formation. Other important biological effects include suppression of anti-coagulating factors (eg, tissue factor pathway inhibitor and protein S) and also increase in plasminogen activator inhibitor 1, which in turn inhibits

fibrinolysis. 73 , 74 Plaque stability is related to the expression of HIF within the plaque, specifically its expression in vascular smooth muscle cells (VSMCs), endothelial cells (ECs) and more importantly foam cells. HIF can also stimulate destabilised angiogenesis occurring in the ischaemic and necrotic atherosclerotic lesion. HIF and HIF-induced genes, especially VEGF, can enhance the haemodynamic instability and fragility of the plaque, thus allows further infiltration of inflammatory cells. 75 , 76

Basic studies have also shown that HIF pathway may be associated with atherosclerosis and vascular calcification. Atherosclerosis involves endothelial activation, lipid accumulation, foam cell formation and VSMCs proliferation. HIF-1 and its associated products such as NF- κ B, VEGF and NO cause EC dysfunction, proliferation, angiogenesis and inflammation. HIF-1 and its product such as ET-1 and MIF, together with cytokines from activated ECs could induce VSMC migration and proliferation. HIF-1 causes migration and inflammation of macrophage with M1 phenotype differentiation, which produces inflammatory cytokines and promotes the formation of foam cells. 75 , 77 However, some studies showed the possible benefits of HIF activation through cholesterol metabolism or inhibiting antigen-presenting cell activation. Vascular calcification involves osteochondrogenic differentiation of VSMCs. HIF-1 and the upregulated RUNX2 and OCN contribute to hypoxia-mediated osteochondrogenic differentiation and extracellular matrix calcification in VSMCs. 78

We reviewed published placebo or competitor-controlled trials of six HIF-PH inhibitors in DD and NDD CKD patients. The pooled incidence of thrombotic side effects by HIF-PHI according to the status of CKD status were summarized in Table 6 and 4B. 14 , 21 , 22 , 23 , 37 , 38 , 39 , 40 , 41 , 42 , 43 , 44 , 46 , 47 , 48 , 49 , 50 , 51 , 79 In DD patients, the incidence of CV events was low (42/1741 [2.4%]). HIF-PH inhibitors were associated with higher incidence of all-cause mortality, hyperkalemia and CV events (Table 6). In NDD patients, the incidence of CV events was even lower (21/1871 [1.1%]). HIF-PHI were associated with insignificantly higher incidence of all-cause mortality, hyperkalaemia and CV events (Table 7). Notwithstanding, one should be aware of the limitations of these pooled data. First, all the clinical trials excluded patients with any history or 'recent' history of thrombotic events (acute coronary syndrome, stroke, or a thromboembolic event) although the exclusion criteria vary between different trials. Second, the duration of treatment was short, which could underestimate the incidence and long-term impact on thrombotic complications. Third, the dose and interval vary between trials despite the target Hb was reasonable in all the trials. Fourth, some side effects might not be well-reported in these clinical trials. Previous ESA trials and basic studies have raised concerns of thrombotic events in HIF-PHI treatment. Indeed, pooled data from clinical trials of HIF-PHI still implies the risk for thrombotic events when high-risk patients have already been excluded from these studies. Large studies with unbiased reports of side effects and long-term follow-up are eagerly awaited. At present, we suggest a careful use of HIF-PHI in DD CKD patients with low CV risk and a restricted off-label use in CKD patients with high CV risk.

Thrombotic and severe events in dialysis-dependent CKD patients of pooled trials

Abbreviations: ACS, acute coronary syndrome; CHD, congestive heart failure; CV, cardiovascular; DVT, deep vein thrombosis; PAOD, peripheral arterial occlusive disease.

Pooled data of 5 clinical trials. 40 , 41 , 48 , 49 , 50

Pooled data of 4 clinical trials. 21 , 37 , 47 , 79

Pooled data of 2 clinical trials (Enarodustat and Molidustat). 44 , 51

Thrombotic and severe events in non-dialysis-dependent CKD patients of pooled trials

Abbreviations: ACS, acute coronary syndrome; CHD, congestive heart failure; CV, cardiovascular; DVT, deep vein thrombosis; PAOD, peripheral arterial occlusive disease.

Pooled data of 3 clinical trials. 39 , 40 , 41

Pooled data of 4 clinical trials. 21 , 22 , 23 , 38

Pooled data of 5 clinical trials (enarodustat, molidustat, desidustat and vadadustat). 14 , 42 , 43 , 44 , 46

<Recommendation> One should follow sizes of cysts up when HIF-1 α PHI are used in patients with polycystic kidney disease.

Both HIF-1 α and HIF-2 α are scarcely detectable in normal kidneys. However, systemic and regional hypoxia result in stabilization of HIF-1 α in tubular epithelial cells and of HIF-2 α in peritubular and glomerular cells. 80 Polycystic kidneys are characterized by chronic stabilization of HIF in cyst lining epithelial and peritubular interstitial cells. This is mainly due to regional hypoxia as a consequence of compression by enlarged cysts and a mismatch between expanding cysts and the vascularization of cyst walls, but not the genetic defects. 81 Data from animal models further support this idea. Tissue PO₂ in cortical surface of Lewis polycystic kidney rats is approximately half of that in control rats. Moreover, renal blood flow and oxygen delivery in the polycystic rats are 60% and 80% lower than control rats. 82

Overproduction of EPO by increased HIF-2 α in chronic hypoxia may explain why patients with autosomal dominant polycystic kidney disease (ADPKD) present with less severe anaemia than patients with other end-stage kidney disease (ESKD). 83 Indeed, serum levels of EPO in ESKD patients due to ADPKD are on average 2-fold higher than in ESKD of other causes. 84 However, the stabilization of HIF in the polycystic disease confers not only such beneficial outcome but also deleterious effects in cyst enlargement. Recent study with mouse ADPKD models in combination with genetic and pharmacological approaches clearly demonstrated that increased levels of HIF-1 α due to chronic hypoxia promote cyst progression. 85 HIF-1 α -dependent apical Ca²⁺ + Cl⁻ secretion is known as a major driving force for cyst fluid secretion. 86 This study also identified the Ca²⁺ + Cl⁻ channel 'anoctamin 1' and the purinergic receptor 'P2Y₂R' as 2 major molecular players in the HIF-1 α -mediated cyst growth. 86 Although the erythropoietic dosage of a HIF-1 α PHI for CKD patients might be different from that used for the animal experiments, undesirable action of HIF-1 α on cyst expansion should be taken into consideration in long-term administration of HIF-1 α PHI to treat anaemia in ADPKD patients.

<Recommendation> Clinical studies have no signals that suggest seizure or neurological complications as an adverse event by HIF-1 α PHI.

HIF is involved in transcriptional responses to hypoxia of many genes, and hence its systemic effect on the cerebrovascular system is of potential concern. In theory, HIF-1 α PHI may increase thromboembolic events or seizures but very few cerebrovascular events have been reported in the clinical studies. One should appreciate that all of these clinical trials have relatively short duration of follow-up and further studies are needed for the evaluation of these potential side effects. Studies on roxadustat in NDD patients have reported dizziness and headache 23 , 87 but not stroke or seizure. 23 , 87 In DD (including both HD and PD) populations, headache (but not stroke or seizure) had been reported in patients treated with roxadustat. 20 In a US study, cerebrovascular accident (1.9%) and complex partial seizure (0.9%) occurred after 19 weeks of roxadustat in ESKD patients receiving maintenance HD, and such adverse events were not observed in the epoetin alfa group. 47 Cerebral infarction (0.7%) was also reported in a study of Japanese population after 24 weeks treatment with roxadustat compared to none in the darbopoietin alfa group. 79 One study reported that vadadustat treatment in NDD CKD patients was associated with slightly higher incidence of headache and dizziness compared with placebo during the 20 weeks of treatment. 42 Headache

was also more common in NDD CKD patients treated with daprodustat for 1 month compared with placebo, 41 although adverse cerebrovascular event did not occur in another study where NDD patients had received 4 weeks of daprodustat. 40 There was no cerebrovascular adverse events or stroke reported In CKD stage 3 to 5 NDD patients treated with molidustat for 16 weeks. 88 , 89

One potential benefits of HIF-1 α PHI is that HIF-1 α PHI may stimulate erythropoiesis by an increase in circulating EPO levels within a physiological range. However, many clinical studies did not employ time points at which circulating EPO levels reach the peak by administration of HIF-1 α PHI.

As hypoxia is a final common pathway to ESKD, HIF-1 α PHI may preserve kidney function in CKD patients. 90 , 91 , 92 , 93 In addition, HIF is a master regulator of defensive mechanisms against hypoxia, HIF-1 α PHI may provide protection against ischaemic diseases such as ischemic heart disease, stroke, peripheral arterial disease and acute kidney injury. 94 , 95 , 96 However, there is no solid clinical evidence to support these expectations, and clinical studies to clarify these issues are awaited.

Previous clinical trials showed a decrease in lipids after HIF-1 α PHI treatment. However, treatment with HIF-1 α PHI decreased both LDL-cholesterol and HDL-cholesterol in these trials. In addition, while some HIF-1 α PHI showed lipid-lowering effects, others did not. Therefore, this effect may be agent specific, and long-term consequences of metabolic changes induced by HIF-1 α PHI remain to be elucidated.

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