



Diabetes Update 2020

Friday, May 1st - Saturday, May 2nd, 2020



Diabetes Update 2020 – Friday Plenary – Dr. Alice Y.Y. Cheng

Question: Are there any studies that include those with type 1 diabetes, or are all of these studies only those with type 2 diabetes?

Answer: All of the CVOTs are done in T2D only. T1D was an exclusion criterion for the studies.

Q: Since the published chronic kidney disease (CKD) [CREDESCENCE] & heart failure [DAPA-HF] trials have much greater representation of patients not previously treated with metformin showing no treatment heterogeneity, why preference combination met+SGLT2i in these patients?

A: Excellent point for DAPA-HF in particular given the high percentage of people without diabetes. However, among those with diabetes in the study, there was still a good percentage of metformin use. As for CREDESCENCE, 60% were still on background metformin. I admit that part of combo with metformin is sentimental.

Q: For patients with an eGFR=30, do we still use SGLT2i?

A: I would still start SGLT2i in a patient with eGFR of 30 if there is good reason to do so (CVD, high ACR, CHF). Based on CREDESCENCE, it is safe to continue the canagliflozin below 30 if the ACR is high warranting treatment.

Q: Any advice on how to encourage GPs on SGLTs/GLP-1RA use for outcome and not just glucose control?

A: That is a key question! Education. Use of analogies. We think of statin and ACE/ARB not just as lipid lowering and BP lowering meds but for vascular protection even in those with LDL <2 and BP at target. That may help.

Q: Is there any evidence for use of SGLT2i in patient with pre-diabetes and cardiovascular disease?

A: The only data on prediabetes patients would come from DAPA-HF that included those without diabetes showing benefit in HFrEF. We have no data for the other therapies in other situations.

Q: What about the coexistence of microvascular issues and the A1c?

A: Achieving A1c remains an important target. This is not a demotion of A1c. It just ensures that we use outcome reducing therapies AND think about the A1c instead of letting the A1c prevent us from using outcome-reducing therapies. The presence of microvascular disease makes it that much more important to achieve A1c target

Q: Is Fournier's gangrene associated with the use of SGLT2i?

A: Very rare complication associated with SGLT2i use. Remember that diabetes in and of itself is a risk factor for Fournier's. Not much to do to prevent it. Discussing genital hygiene is important. Thinking about the possibility when the pain is out of keeping with the physical exam. But we should be thinking of that anytime.



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Q: Do you any specific advice for managing patients with significant underlying retinopathy?

A: Ensure they are getting proper management from retinal specialist (anti-VEGF injections, laser treatment, surgery etc.) Then I would treat to control glycemia with any of the options available to me, including GLP1RA as the association is related to rapid reduction in A1c and not the drugs themselves. As long as the retinopathy is being treated, we can bring the sugars down.

Q: Is a dietitian involved in all of these patients in these studies?

A: In these CVOTs, the dietary advice is consistent in both groups and aligns with clinical practice in the area. There is no specific dietary intervention. The study of dietary and lifestyle changes and CV outcomes was disappointing unfortunately - LOOK AHEAD.

Q: How safe is SGLT2i use especially for someone with multiple comorbidities. When would you not prescribe it?

A: I would not prescribe in someone with urinary incontinence, immobility (can not get to bathroom safely), prone to falls, short life expectancy.

Q: Will you start SGLT2i on an 80-year-old patient with eGFR around 30-40 and no prior heart disease?

A: If good 80-year-old with good continence, mobility and has compelling reason to use (CVD, CKD, CHF) then yes.

Q: What eGFR levels are you comfortable with in terms of using metformin and SGLT2i in a patient with CKD?

A: Metformin >30 mL/min/1.73m². SGLT2i start if >30 mL/min/1.73m²

Q: I did not hear about sulfonylurea? Are they obsolete?

A: Sulfonylureas are solely for achieving A1C target. So, if after using outcome-reducing therapy and selecting therapies that do not cause hypoglycemia, a patient still needs glucose lowering, then I would use a SU. Or in the self-paying patient where cost is most important.