Examining the Influence of Cardiovascular Outcome Trials: Is It the Heart of Diabetes?

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Disclosure

• Melody Hartzler – Janssen, Valeritas and NovoNordisk (Speaker’s Bureau)

• All other planners, presenters, reviewers, and APhA staff of this session report no financial relationships relevant to this activity.
CPE Information

• Target Audience: Pharmacists
• ACPE#: 0202-0000-19-064-L01-P
• Activity Type: Application-based
Learning Objectives

• Evaluate the potential benefits of antidiabetic drug therapy beyond lowering A1c effects.
• Summarize the results of cardiovascular outcome trials (CVOTs) of antidiabetic drug therapy.
• Design an individualized, evidence-based pharmacotherapeutic plan for a patient with type 2 diabetes.
• Recommend strategies for identifying and integrating into practice the results of new CVOT literature involving antidiabetic drug therapy.
Session Announcements
Beyond A1c: Possible CV Benefits

- Reductions in glucose variability
- Reductions in uric acid [Sodium-glucose cotransporter-2 inhibitors (SGLT2i)]
- Weight loss
- BP reduction (SGLT2i)
- Increased cardiac contractility (GLP-1 Receptor Agonist)
- Reduction in preload and afterload (SGLT2i)
- Reduction in arterial stiffness (SGLT2i)

Meet CJ

• 55-year-old African American male with a history of CABG x 3
• Type 2 DM x 15 years
• HTN
• Hyperlipidemia (high TG and LDL)

• Current medications include:
  • clopidogrel 75 mg orally daily
  • ASA 325 mg orally daily
  • metformin 1,000 mg orally twice daily
  • glipizide 5 mg orally twice daily
  • lisinopril/HCTZ 20-12.5, two tablets orally daily
  • metoprolol 25 mg ER orally daily
  • atorvastatin 40 mg orally daily
Meet CJ

- Height 5’9”
- Weight 260 lb
- BMI: 38.4 kg/m²

- BP today is 145/87 mm Hg, Pulse of 62 bpm

- Today CJ is here for follow-up for his diabetes. A1c is 9.5%, other labs are WNL, including renal function.

- During your initial review of systems with CJ you learn that his blood glucose levels are fluctuating anywhere from 55 to 400 mg/dL in a given day.
Which of the following cardiovascular (CV) risk reduction strategies should we think about first for CJ?

a) Reductions in glucose variability
b) Weight loss
c) BP reduction
d) Reduction in uric acid
Glucose Variability

• GV is also associated with:
  • Cardiovascular autonomic neuropathy in patients with type 1 diabetes¹
  • Worse outcomes for MI patients undergoing PCI²
  • Increased production of reactive oxygen species leading to detrimental effect on endothelial tissue³

Glucose Variability

• A recent meta-analysis showed minimizing GV is accompanied by a reduction of carotid intima-media thickness with an estimated magnitude between 0.09 and 0.47 mm.
  • This is consistent with an estimated 11% to 59% reduction in risk of MI and a 13% to 70% reduction in risk of stroke.
  • Minimizing GV also resulted in an improvement in insulin resistance measures.

Glucose Variability

• DEVOTE-2\textsuperscript{1}
  • High day-to-day fasting glycemic variability is associated with increased risks of severe hypoglycemia and all-cause mortality.

• Higher level of variability could be the cause of left ventricular remodeling in the chronic phase in patients with acute MI regardless of the level of A1c.\textsuperscript{2}

Uric Acid

• Studies are mixed
  • Some studies that have controlled for multiple risk factors suggest that elevated uric acid may be an independent risk factor for both cardiovascular disease and kidney disease.
  • Other studies have shown that an elevated level of uric acid predicts the development of hypertension, obesity, kidney disease, and diabetes.
  • Some reports of cardiovascular and renal benefits when lowering uric acid in preliminary clinical trials.

• We need to understand more about its role
  • Uric acid can be pro-inflammatory in adipocytes and vascular tissue but also can function as an antioxidant and have beneficial effects for neurological conditions.

Cardiovascular Risk Data for Diabetes Medications
**Metformin**

- Proposed CV Benefits
- Studies have demonstrated that metformin improves CV outcomes compared with sulfonylureas.
- Proposed mechanisms for CV protective effect of metformin¹:
  - Improved glucose control, reduction in methylglyoxal levels, decrease in VLDL secretion and plasma triglyceride levels, and reduced postprandial lipemia

- Evidence
- UKPDS showed metformin significantly decreased:
  - MI, coronary deaths, and all-cause mortality in newly diagnosed T2DM patients (n = 753) with low CVD risk whose body weight was >120% of their ideal weight.²,³
  - 10-year follow-up of UKPDS, metformin-treated obese T2DM patients (n=342) continued to show a reduction in MI and death from any cause⁴

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Sulfonylurea (SU) CVD Data

• Controversial
  • UKPDS,\(^1\) ADVANCE\(^2\) and ACCORD\(^3\) failed to demonstrate an increase in either CVD mortality or morbidity in sulfonylurea-treated T2DM patients.
  • In the ADVANCE trial, severe hypoglycemia was associated with a significant increase in major macrovascular events and death from a cardiovascular cause.\(^2\)

• Results of meta-analyses of studies of CV effects of SU are mixed\(^4\)

• In a recent study the AGi, acarbose, was compared with SU as add-on therapy with metformin – significantly lower risks\(^5\)

• During a mean follow-up of 1.1 years, SU monotherapy versus metformin monotherapy, was associated with\(^6\):
  • an increased risk of MI, all-cause mortality, and severe hypoglycemia
  • a trend towards increased risks of ischemic stroke and cardiovascular death

Pioglitazone and CV Impact

- Concerns with pioglitazone:
  - Fluid retention and ↑ heart failure

- Proposed benefits:
  - BP regulation - ↓ BP
  - Improved endothelial function
  - Reduced vascular inflammation
  - Lipid metabolism - ↑ HDL (~15%), ↓ TG
  - Reduced smooth muscle cell proliferation
  - Reduced fibrinolysis
  - ↓ C-reactive protein

- In patients with diabetes, pioglitazone compared with glimepiride:
  - Slows increase in carotid intima-media thickness and progression of coronary atherosclerosis

Pioglitazone CVD Data

• PROactive included patients with T2DM, evidence of extensive macrovascular disease\(^1,2\)
  - **Primary outcome** – MACE + leg revascularization and major leg amputation - Not significantly different

• IRIS included patients with insulin resistance, recent ischemic stroke or TIA\(^3\)
  - **Primary outcome** - Fatal or nonfatal stroke or MI occurred in 9.0% of pioglitazone group vs. 11.8% of placebo group (HR 0.76; 95% CI, 0.33 to 0.69; \(p<0.001\)) - **NNT – 36**
  - **Safety outcomes** occurring more in pioglitazone group - weight gain, edema, bone fracture requiring surgery or hospitalization

Pioglitazone CVD Data

• 3 Meta-analyses from 2017:
  • Systematic review included patients with insulin resistance, prediabetes, and T2DM\(^1\) - decreased risk of major adverse cardiac events (MACE) (RR 0.83; 95% CI, 0.72 to 0.97)
  • Systematic review focused on secondary stroke prevention\(^2\) – decreased risk of recurrent stroke (HR 0.68; 95% CI, 0.50 to 0.92; \(p=0.01\)) and risk of all major vascular outcomes (HR 0.75; 95% CI, 0.64 to 0.87; \(p=0.001\))
  • Focused on patients with CVD\(^3\) – decreased risk of recurrent MACE (RR 0.74; 95% CI, 0.60 to 0.92)

Meet SM

- 62-year-old African American female with a past medical history of T2DM, hyperlipidemia, HTN, vitamin D deficiency, and PAD.
- BMI 32.1 kg/m², Basic metabolic panel WNL
- She reports checking BG sometimes daily or every other day with fasting
- BG ranging 150 – 170 mg/dL.

- Current medications include:
  - metformin 1000 mg orally twice a day
  - rosuvastatin 5 mg orally daily
  - aspirin 81 mg orally daily
  - vitamin D 1000 IU 2 tabs orally daily
  - amlodipine 5 mg orally daily
  - lisinopril 20 mg orally daily
  - coral calcium 1000 mg orally twice a day
  - esomeprazole 40 mg orally daily

A1c today is 7.7%
Knowing the potential for CV benefits, adding which of the following medications is the next best step for managing SM’s T2DM?

a) Acarbose
b) Bromocriptine
c) Glimepiride
d) Pioglitazone
Cardiovascular Outcomes Trial (CVOT) Design
To adequately evaluate the CV safety of type 2 diabetes drugs in development, future development programs should include:

- Phase 2 and 3 trials that include patients at higher risk for CV events, are of sufficient size and duration to enable enough CV events to allow for a meaningful evaluation of CV risk
- Be designed to facilitate later meta-analysis
- The CV events should include CV mortality, MI, and stroke
- Can also include hospitalization for ACS, urgent revascularization procedures, and other end points, such as HF hospitalization

CV Death

Nonfatal MI

MACE

Additional Endpoints

Non-fatal Stroke

1. Hospitalizations for ACS Events
2. Revascularization
3. CHF

FDA Guidance on CVOTs

• Independent adjudication of CV events
• Meta-analysis of the phase 2 and 3 trials at the end of the research program
  • Following a protocol developed in advance that prespecifies the end points to be assessed and the statistical methods
• Analysis of premarketing data comparing the CV events occurring with the agent to those occurring with the control group and demonstrating that the upper limit of a two-sided 95% CI of the estimated risk ratio is <1.8
  • If this cannot be done through the meta-analysis described above, it should be accomplished in a separate, large CV safety trial

FDA Guidance on CVOTs

• For agents whose 95% CI upper limit falls between 1.3 and 1.8 in premarketing analysis, completion of a post-marketing trial or continuation of a premarketing trial after approval may be needed to conclusively show that the upper limit of the two-sided 95% CI is <1.3 with a “reassuring” point estimate of overall CV risk
  • It has been proposed that the required number of events for such a trial would be 600–700
• If 95% CI is <1.3, no further study may be necessary.
• Relative Risk should not be more than 1

Aim: Demonstrate CV Benefit

Difference between treatment arms in biomarkers

Significant reduction in CV outcomes vs. active comparator

Cardiovascular Outcomes Trials - Efficacy

Treatment vs. comparator

Cardiovascular Outcomes Trials - Safety

Aim: Demonstrate CV Safety
Small/no difference in biomarkers such as A1c
Non-inferiority vs. placebo

Treatment vs. placebo

## Major Trials with Intensive Glycemic Control & Long-Term Follow-up of Cardiovascular Outcomes

<table>
<thead>
<tr>
<th>Study</th>
<th>Diabetes Type</th>
<th>CV Composite</th>
<th>MI</th>
<th>CV Mortality</th>
<th>All-cause Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCCT/EDIC</td>
<td>Type 1</td>
<td>⬇</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UKPDS</td>
<td>Type 2</td>
<td></td>
<td>⬇</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCORD</td>
<td>Type 2</td>
<td>↔</td>
<td>↔</td>
<td>↑</td>
<td>↔</td>
</tr>
<tr>
<td>ADVANCE</td>
<td>Type 2</td>
<td>↔</td>
<td>↔</td>
<td>↔</td>
<td>↔</td>
</tr>
<tr>
<td>VADT</td>
<td>Type 2</td>
<td>⬇</td>
<td>↔</td>
<td>↔</td>
<td>↔</td>
</tr>
</tbody>
</table>

↔ = Neutral Effect, ↑ increase, ↓ decrease

Modified from Table 1. Cefalu WT et al. *Diabetes Care.* 2018;41:14-31.
Diabetes CVOT Trials

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Primary literature results from antidiabetic therapy Cardiovascular Outcomes Trials (CVOT)
DPP-4 Inhibitors (DPP-4i) and Proposed CV Benefits

• Potential direct effects on:
  • Heart
    • ↑ glucose uptake, ↑ ischemia tolerance
  • Peripheral arteries
    • ↓ intima media thickness progression, improved endothelial function?

• Other impacts on CV function:
  • Renal function
    • ↓ albumin excretion
  • Inflammatory responses
    • ↓ expression of inflammatory cytokines (TNF-α, IL-1β, and others), ↓ C-reactive protein
  • Platelet function
    • ↓ platelet aggregation?

• ↑ rate of hospitalization for congestive heart failure – saxagliptin (significant) vs. alogliptin (non-significant)

## Baseline Characteristics of DPP-4i CVOTs

<table>
<thead>
<tr>
<th></th>
<th>EXAMINE (alogliptin)</th>
<th>SAVOR-TIMI 53 (saxagliptin)</th>
<th>TECOS (sitagliptin)</th>
</tr>
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<tbody>
<tr>
<td>N</td>
<td>5,380</td>
<td>16,492</td>
<td>14,724</td>
</tr>
<tr>
<td>Mean age, yr</td>
<td>61</td>
<td>65</td>
<td>66</td>
</tr>
<tr>
<td>Mean BMI, kg/m²</td>
<td>28.7</td>
<td>31</td>
<td>30.2</td>
</tr>
<tr>
<td>Previous CV Disease, %</td>
<td>100</td>
<td>78.4</td>
<td>74</td>
</tr>
<tr>
<td>Mean A1c %</td>
<td>8</td>
<td>8</td>
<td>7.2</td>
</tr>
<tr>
<td>Mean duration of diabetes, yr</td>
<td>7.2</td>
<td>11.9</td>
<td>11.6</td>
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<tr>
<td>Insulin use, %</td>
<td>29.9</td>
<td>40.9</td>
<td>23.2</td>
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</table>

## Other Study Design for DPP-4i CVOTs

<table>
<thead>
<tr>
<th>CV Risk status</th>
<th>EXAMINE (alogliptin)</th>
<th>SAVOR-TIMI 53 (saxagliptin)</th>
<th>TECOS (sitagliptin)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVD history</td>
<td>1.5 (3.3)</td>
<td>2.1 (2.9)</td>
<td>3.0</td>
</tr>
<tr>
<td>CVD history or risk factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median (max) time to follow-up, yr</td>
<td>1.5 (3.3)</td>
<td>2.1 (2.9)</td>
<td>3.0</td>
</tr>
</tbody>
</table>

## Results for DPP-4i CVOTs

<table>
<thead>
<tr>
<th></th>
<th>EXAMINE (alogliptin)</th>
<th>SAVOR-TIMI 53 (saxagliptin)</th>
<th>TECOS (sitagliptin)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary outcome</td>
<td>3-point MACE</td>
<td>3-point MACE</td>
<td>4-point MACE</td>
</tr>
<tr>
<td>Results of primary outcome</td>
<td>Occurred in 11.3% (alogliptin) and in 11.8% (placebo); (HR alogliptin, 0.96; upper boundary of one-sided repeated CI, 1.16; p&lt;0.001 noninferiority; p=0.32, superiority)</td>
<td>Occurred in 7.3% (saxagliptin) and in 7.2% (placebo); (HR saxagliptin, 1.00; 95% CI, 0.89 to 1.12; p&lt;0.001 noninferiority, p=0.99 superiority)</td>
<td>Occurred in 11.4% of (sitagliptin) and in 11.6% (placebo); (HR sitagliptin, 0.98; 95% CI, 0.88 to 1.09; p&lt;0.001 noninferiority)</td>
</tr>
</tbody>
</table>

The prescriber wants to know what trial’s results will provide him with additional information regarding the CV safety of using linagliptin when compared to an active control. For which of the following trial results should the prescriber watch?

a) CARMELINA
b) CAROLINA
c) EXAMINE
d) TECOS
## Recently Completed DPP-4i CVOTs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Study</th>
<th>Main inclusion criteria</th>
<th>Median follow-up</th>
<th>Primary outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linagliptin vs. glimepiride</td>
<td>CAROLINA(^1,3)</td>
<td>T2DM + history of CVD OR diabetes end-organ damage OR age ≥ 70 yr OR ≥ 2 risk factors for CVD (n = 6,072)</td>
<td>~ 8.3 yr (enrollment ended 2012)</td>
<td>3-point MACE Completed 2018</td>
</tr>
<tr>
<td>Linagliptin vs. placebo</td>
<td>CARMELINA(^1,4,5)</td>
<td>T2DM + high CV risk (confirmed CVD) and/or presence of CKD (n = 7,003)</td>
<td>4.5 yr</td>
<td>3-point MACE Completed 2018</td>
</tr>
</tbody>
</table>

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Meet JJ

• 52-year-old African-American male, BMI 32.1 kg/m²
• A1c 8%, SCr 0.9 mg/dL, Basic metabolic panel WNL
• Past Medical History:
  • Type 2 DM (x 1 yr)
  • Stroke
• JJ’s BG log book reveals:

<table>
<thead>
<tr>
<th>Timing of BG values</th>
<th>Range of BG values (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting BG</td>
<td>120 – 150</td>
</tr>
<tr>
<td>2-hr postprandial</td>
<td>210 - 250</td>
</tr>
</tbody>
</table>

• Current medications:
  • metformin 1000 mg orally twice daily
  • atorvastatin 40 mg orally nightly
  • aspirin 81 mg orally daily
In addition to encouraging intensive lifestyle modifications, which of the following would be the BEST option to optimize JJ's T2DM management and minimize his risk for heart failure?

a) Alogliptin  
b) Linagliptin  
c) Saxagliptin  
d) Sitagliptin
GLP-1 RA and Proposed CV Benefit

- Effects may vary depending on the particular GLP-1 RA
  - Different characteristics of GLP-1 RA thought to be related to differences in GLP-1 RA CVOT results beyond glucose variability
  - Decreased CV events noted with GLP-1 RA that result in greater decreases in A1c, body weight, and SBP
  - Less risk of severe hypoglycemia

- GLP-1 RA address other CV risk factors by decreasing:
  - SBP by 2-3 mm Hg
  - Cholesterol – LDL, TC, TG
  - Body weight
  - Waist circumference

GLP-1 RA and Proposed CV Benefit

• Potential direct effects on:
  • Heart
    • Increasing myocardial contractility, glucose uptake, and ischemia tolerance
  • Peripheral arteries
    • Increasing endothelial function and plaque stability
    • Decreasing arterial stiffness and vascular inflammation/inflammatory responses

• Other impacts on CV function:
  • Renal function
    • May see acute increase in glomerular filtration
    • Emerging evidence shows GLP-1 RA decrease albumin excretion
  • Decreased inflammatory responses
    • Reactive oxygen species, expression of inflammatory cytokines (TNF-α, IL-1β, and others),
    • C-reactive protein
  • Platelet function
    • Decreased platelet aggregation

## Baseline Characteristics of GLP-1 RA CVOTs

<table>
<thead>
<tr>
<th></th>
<th>ELIXA (lixisenatide)</th>
<th>EXSCEL (exenatide)</th>
<th>LEADER (liraglutide)</th>
<th>SUSTAIN-6 (semaglutide)</th>
<th>Harmony Outcomes (albiglutide)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>6,075</td>
<td>14,000</td>
<td>9,340</td>
<td>3,297</td>
<td>9,463</td>
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<tr>
<td>Mean age, yr</td>
<td>60</td>
<td>62</td>
<td>65</td>
<td>64.6</td>
<td>64.1</td>
</tr>
<tr>
<td>Mean BMI, kg/m²</td>
<td>30</td>
<td>31.8</td>
<td>32.5</td>
<td>32.8</td>
<td>32.3</td>
</tr>
<tr>
<td>Previous CV Disease, %</td>
<td>100</td>
<td>73.1</td>
<td>81</td>
<td>83</td>
<td>70</td>
</tr>
<tr>
<td>Mean A1c %</td>
<td>7.7</td>
<td>8</td>
<td>8.7</td>
<td>8.7</td>
<td>8.7</td>
</tr>
<tr>
<td>Mean duration of diabetes, yr</td>
<td>9.3</td>
<td>12</td>
<td>12.8</td>
<td>8.1</td>
<td>14.1</td>
</tr>
<tr>
<td>Insulin use, %</td>
<td>37.8</td>
<td>46.3</td>
<td>44.5</td>
<td>58</td>
<td>60</td>
</tr>
</tbody>
</table>

## Other Study Design for GLP-1 RA CVOTs

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<td>CVD history or risk factors</td>
<td>CVD history or risk factors</td>
<td>CVD history</td>
</tr>
<tr>
<td>Median (max) Time to follow-up, yr</td>
<td>1.9 (3.9)</td>
<td>3.2 (4.4)</td>
<td>3.8</td>
<td>2.1</td>
<td>1.6 (2.6)</td>
</tr>
<tr>
<td>MACE (events)</td>
<td>805</td>
<td>1,744</td>
<td>1,302</td>
<td>254</td>
<td>766</td>
</tr>
</tbody>
</table>

Type 2 DM and acute coronary event within 180 days of screening
Multicenter, randomized, double-blind, placebo-controlled

Primary Outcome: 4-point MACE-CV death, nonfatal MI, nonfatal stroke, or hospitalization for unstable angina. Powered for noninferiority and superiority.

The primary outcome occurred in 13.4% of the lixisenatide group and in 13.2% of the placebo group (HR in the lixisenatide group, 1.02; 95% CI, 0.89 to 1.17; p<0.001 noninferiority, p=0.81 superiority).

ELIXA Renal Outcomes

• Lixisenatide was associated with:
  • A reduction in urinary albumin-to-creatinine ratio (UACR) of 39.18% for the macroalbuminuria group (HR 14.97; -68.53 to -9.84; p = 0.007) from baseline to week 108
  • Significant reduction in new onset macroalbuminuria (HR 0.815; 95% CI: 0.665-0.999; p = 0.0491) when adjusted for baseline and on-trial A1c
  • No significant differences in eGFR decline were identified between treatment groups in any UACR subgroup

EXSCEL (exenatide)

Type 2 DM +/- previous CV disease (70% previous disease/30% no previous disease)
Multicenter, randomized, double-blind, placebo-controlled

Primary Outcome: 3-point MACE-CV death, nonfatal MI, nonfatal stroke. Powered for noninferiority and superiority.

The primary outcome occurred in 11.4% of the exenatide group and in 12.2% of the placebo group (HR in the exenatide group, 0.91; 95% CI, 0.83 to 1.00; p<0.001 noninferiority, p=0.06 superiority).

Showed noninferiority but not superiority

LEADER (liraglutide)

Type 2 DM, previous CV disease or CV risk factor
Multicenter, randomized, double-blind, placebo-controlled

Primary Outcome: 3-point MACE-CV death, nonfatal MI, nonfatal stroke. Powered for noninferiority and superiority.

The primary outcome occurred in 13.0% of the liraglutide group and in 14.9% of the placebo group
(HR in the liraglutide group, 0.87; 95% CI, 0.78 to 0.97; p=0.01 superiority).

NNT for primary outcome = 53

LEADER (liraglutide): Secondary Outcomes

• Lower rates in liraglutide vs. placebo - significant findings
  • Expanded composite (3-point MACE + coronary revascularization or hospitalization for unstable angina pectoris or heart failure) – 20.3% vs. 22.7% (HR, 0.88; 95% CI, 0.81 to 0.96; p=0.005)
  • Death from any cause – 8.2% vs. 9.6% (HR, 0.85; 95% CI, 0.74 to 0.97; p=0.02)
  • Death from CV causes – 4.7% vs. 6.0% (HR, 0.78; 95% CI, 0.66 to 0.93; p=0.007)
  • Microvascular event – 7.6% vs. 8.9% (HR, 0.84; 95% CI, 0.73 to 0.97; p=0.02)
    • Nephropathy – 5.7% vs. 7.2% (HR, 0.78; 95% CI, 0.67 to 0.92; p=0.003)

• Nonsignificant findings
  • Prespecified – nonfatal stroke; coronary revascularization, hospitalization for unstable angina pectoris, hospitalization for heart failure; retinopathy
  • Not-prespecified - MI – fatal, silent; fatal stroke; TIA

LEADER (liraglutide): Additional Analysis

• Post-hoc analysis of CV events
  • LDL groups (LDL < 50 mg/dL, LDL 50 to 70 mg/dL, LDL > 70 mg/dL)
  • HDL and non-HDL
  • Statin user vs. non-statin users
  • Liraglutide benefited all groups

• Diabetes-related foot ulcer (DFU) incidence + post-hoc analysis of DFU-related complications
  • Patients reporting at least 1 DFU: similar between groups – 3.8% in liraglutide vs. 4.1% placebo (HR, 0.92; 95% CI, 0.75 to 1.13; p=0.41)
  • DFU-related complications
    • Liraglutide ↓ amputations vs. placebo (HR, 0.65; 95% CI, 0.45 to 0.95; p=0.03)
    • No significant difference between groups in incidence of foot infections, involvement of underlying structures, or peripheral revascularization

**SUSTAIN-6 (semaglutide)**

**Type 2 DM, previous CV disease or CV risk factor**

**Multicenter, randomized, double-blind, placebo-controlled**

**Primary Outcome:** 3-point MACE-CV death, nonfatal MI, nonfatal stroke. Powered for noninferiority.

*not prespecified for superiority*

The primary outcome occurred in 6.6% of the semaglutide group and in 8.9% of the placebo group

(HR in semaglutide, 0.74; 95% CI, 0.58 to 0.95; p<0.001 noninferiority).

NNT for primary outcome = 43

SUSTAIN-6 (semaglutide): Secondary Outcomes

• **Lower** rates in semaglutide vs. placebo - significant findings
  • Expanded composite (3-point MACE + coronary revascularization or hospitalization for unstable angina or heart failure) – 12.1% vs. 16.0% (HR, 0.74; 95% CI, 0.62 to 0.89; p=0.002)
  • All-cause death, nonfatal MI, or nonfatal stroke – 7.4% vs. 9.6% (HR, 0.77; 95% CI, 0.61 to 0.97; p=0.03)
  • Nonfatal stroke – 1.6% vs. 2.7% (HR, 0.61; 95% CI, 0.38 to 0.99; p=0.04)
  • Revascularization – 5.0% vs. 7.6% (HR, 0.65; 95% CI, 0.50 to 0.86; p=0.003)
  • New or worsening nephropathy – 3.8% vs. 6.1% (HR, 0.64; 95% CI, 0.46 to 0.88; p=0.005)

• **Higher** rate in semaglutide vs. placebo - significant finding
  • Retinopathy complications – 3.0% vs. 1.8% (HR, 1.76; 95% CI, 1.11 to 2.78; p=0.02)

• Non-statistically significant findings
  • Death from any cause, death from CV cause, nonfatal MI, hospitalization for unstable angina pectoris, hospitalization for heart failure

Harmony Outcomes (albiglutide)

**Type 2 DM, previous CV disease or CV risk factor**

Multicenter, randomized, double-blind, placebo-controlled

**Primary Outcome:** 3-point MACE - CV death, nonfatal MI, nonfatal stroke. Powered for noninferiority and superiority.

The primary outcome occurred in 7% of the albiglutide group and in 9% of the placebo group

(HR in albiglutide, 0.78; 95% CI, 0.68 to 0.90; p<0.001 noninferiority, p = 0.006 superiority).

NNT for primary outcome = 50

Hernandez AF et al. (Harmony Outcomes) *Lancet*. 2018; [http://dx.doi.org/10.1016/S0140-6736(18)32261-x](http://dx.doi.org/10.1016/S0140-6736(18)32261-x);
Remember JJ

• 52-year-old African-American male, BMI 32.1 kg/m²
• A1c 8%, SCR 0.9 mg/dL, BMP WNL
• Past Medical History:
  • Type 2 DM (x 1 yr)
  • Stroke
• JJ’s BG log book reveals:

<table>
<thead>
<tr>
<th>Timing of BG values</th>
<th>Range of BG values (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting BG</td>
<td>120 – 150</td>
</tr>
<tr>
<td>2hr postprandial</td>
<td>210 - 250</td>
</tr>
</tbody>
</table>

• Current medications:
  • metformin 1000 mg orally twice daily
  • atorvastatin 40 mg orally nightly
  • aspirin 81 mg orally daily
The results of the 5 published GLP-1 RA CVOT may not apply to JJ due to which of the following?

a) A1c
b) BMI
c) Duration of diabetes
d) Previous CV disease
## Ongoing GLP-1 RA CVOTs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Study</th>
<th>Main inclusion criteria</th>
<th>Median follow-up</th>
<th>Primary outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dulaglutide</td>
<td>REWIND&lt;sup&gt;1-4&lt;/sup&gt;</td>
<td>T2DM and ≥ 50 yr with CVD or ≥ 55 yr and subclinical vascular disease OR ≥ 60 yr + ≥ 2 CV risk factors (n = 9,901)</td>
<td>Anticipate ~ 8 yr</td>
<td>3-point MACE Anticipated completion 2018</td>
</tr>
<tr>
<td>Oral semaglutide</td>
<td>PIONEER&lt;sup&gt;6&lt;/sup&gt;</td>
<td>T2DM and ≥ 50 yr with CVD OR ≥ 60 yr + ≥ 1 CV risk factor (n = 3,176)</td>
<td>19 months</td>
<td>3-point MACE Anticipated completion 2018</td>
</tr>
</tbody>
</table>

Meet MP

• MP, a 60-year-old female with a history of T2DM, hypercholesterolemia, cerebrovascular accident, and migraines, presents to your diabetes clinic for medication management. She currently has 1+ edema in both lower extremities and significant abdominal obesity.

• Currently BP is well controlled at 154/84 mm Hg, Pulse of 82 bpm

• Pertinent current medications:
  • clopidogrel 75 mg orally daily
  • rosuvastatin 40 mg orally daily
  • alirocumab 150 mg SC every 2 weeks
  • carvedilol 12.5 mg orally twice daily
  • metformin 1,000 mg orally twice daily
  • insulin glargine 130 units SC daily
  • insulin lispro ~63 units/day SC divided 3-4 times
  • hydrochlorothiazide 25 mg orally daily
  • lisinopril 40 mg orally daily
Meet MP

- **Labs**
  - A1c: 10.5%
  - Vitamin D 29 ng/mL
  - CBC WNL
  - TC 248, LDL 176, TG 145, HDL 43 (mg/dL)
  - TSH 2.35 mIU/ml, T4 6.6 mcg/dL, T3 Uptake 24%, Free Thyroxine Index 1.6, T3 123 ng/dL

- **Interventions**
  - Vitamin D/K2 with 3,000 IU Vitamin D₃ orally daily
  - Continue to monitor thyroid (not optimal)
  - Order Insulin Pump with a continuous glucose monitor
  - Increase carvedilol to 25 mg orally twice daily
Your team is starting MP on a continuous infusion of insulin to reduce her insulin requirements and decrease her glucose variability.

- Starting dose before auto mode: basal 2 units/hr, bolus 4.6 g/unit, active insulin time 3 hours, Correction bolus 1 unit 18 mg/dL, Target BG 100-120 mg/dL

What additional medication class has the MOST potential for MP to further reduce insulin requirements, lose weight, and reduce cardiovascular risk?

a) SGLT-2is  
b) GLP-1 RAs  
c) TZDs  
d) Alpha-glucosidase inhibitors
MP’s current CGM profile looks like this with her first week of semaglutide 0.5 mg SC once weekly (switched from a few weeks of long-acting exenatide).
MP Case Follow-up

- MP was placed on a Medtronic 670g Insulin pump with CGM
- CGM below is 7 days after pump start. (manual mode)
MP Case Follow-up

• Patient achieved improved glucose variability
• Decreased total daily dose (TDD) of insulin from 193 units/day down to 75 units.

• Next Steps:
  • Patient now with anxiety, depression
  • Blood pressure still elevated
  • R/O hypercortisolism
    • Dexamethasone suppression test ordered
    • 4 point salivary cortisol
SGLT2i and ASCVD Risk Reduction

• Agents address other cardiovascular risk factors
  • BP (reductions in SBP up to 6 mm Hg)
  • Weight
  • Glucose control
• Along with blocking glucose reabsorption, SGLT2i cause a reduction in protein and sodium reabsorption in the nephron, which results in osmotic diuresis, milder than other diuretic agents.
• This loss of fluid volume activates the renin-angiotensin-aldosterone (RAAS) system and starts a counter-regulatory response to maintain homeostasis.
• SGLT2i provide documented benefits for reducing preload and afterload work on the heart.

**SGLT2i and ASCVD Risk Reduction**

- Despite the potential for SGLT-2i to cause a small, dose-related LDL increases sometimes accompanied by HDL increases, there are no CV outcomes trials at this time demonstrating that the LDL increases translate into increased CV events.
- SGLT2i have been shown in multiple trials to provide a CVD benefit while aiding in lowering BP.

## Baseline Characteristics of SGLT2i CVOTs

<table>
<thead>
<tr>
<th></th>
<th>EMPA-Reg (empagliflozin)</th>
<th>CANVAS Program (canagliflozin)</th>
<th>DECLARE-TIMI (dapagliflozin)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>7034</td>
<td>10142</td>
<td>17160</td>
</tr>
<tr>
<td>Mean Age, yr</td>
<td>63.1</td>
<td>63</td>
<td>63.9</td>
</tr>
<tr>
<td>Mean BMI, kg/m²</td>
<td>30.6</td>
<td>31.9</td>
<td>32.1</td>
</tr>
<tr>
<td>Previous CV Disease, %</td>
<td>&gt;99</td>
<td>66</td>
<td>40.6</td>
</tr>
<tr>
<td>Mean A1c %</td>
<td>8.1</td>
<td>8.2</td>
<td>8.3</td>
</tr>
<tr>
<td>Mean duration of diabetes, yr</td>
<td>&gt;57% with a diabetes duration &gt;10 years</td>
<td>13.5</td>
<td>11.0</td>
</tr>
<tr>
<td>Insulin use, %</td>
<td>48.0</td>
<td>50.4</td>
<td>40.9</td>
</tr>
</tbody>
</table>

### Other Study Design for SGLT-2i CVOTs

<table>
<thead>
<tr>
<th></th>
<th>EMPA-Reg (empagliflozin)</th>
<th>CANVAS Program (canagliflozin)</th>
<th>DECLARE-TIMI (dapagliflozin)</th>
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</thead>
<tbody>
<tr>
<td>CV Risk status</td>
<td>CVD History</td>
<td>CVD history or risk factors</td>
<td>CVD history or risk factors</td>
</tr>
<tr>
<td>Median time to follow up, yr</td>
<td>3.2</td>
<td>2.4</td>
<td>4.2</td>
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<tr>
<td>MACE, events</td>
<td>772</td>
<td>1,011</td>
<td>1559</td>
</tr>
</tbody>
</table>

EMPA-Reg (empagliflozin)

Type 2 DM, high risk for CV Events, BMI ≤ 45 kg/m², Multicenter, randomized, double blind, placebo-controlled,

Primary Outcome: 3 point MACE - CV death, nonfatal MI, nonfatal stroke. Powered for noninferiority and superiority

The primary outcome occurred in 10.5% of the empagliflozin group and in 12.1% of the placebo group (HR in the empagliflozin group, 0.86; 95.02% confidence interval, 0.74 to 0.99; P=0.04 for superiority).

NNT for primary outcome = 63

EMPA-Reg (empagliflozin)

• There were no significant between-group differences in the rates of MI or stroke, but in the empagliflozin group there were significantly lower rates of:
  • death from CV causes (3.7% vs. 5.9% in the placebo group; 38% relative risk reduction),
  • hospitalization for heart failure (2.7% and 4.1%, respectively; 35% relative risk reduction),
  • and death from any cause (5.7% and 8.3%, respectively; 32% relative risk reduction).

Incident or worsening nephropathy occurred in 12.7% of empagliflozin group and in 18.8% of placebo group (HR 0.61; 95% CI, 0.53-0.70; P<0.001).

Doubling of SCr occurred in 1.5% of empagliflozin group and 2.6% of placebo group, a significant relative risk reduction of 44%.

**CANVAS (canagliflozin)**

Type 2 DM, history or high risk CVD
Multicenter, randomized, double-blind, placebo-controlled, parallel-group

Primary outcome: 3 point MACE, CV death, nonfatal stroke, and nonfatal MI

The rate of the primary outcome was lower with canagliflozin than with placebo (occurring in 26.9 vs. 31.5 participants per 1000 patient-years; hazard ratio, 0.86; 95% confidence interval [CI], 0.75 to 0.97; P<0.001 for noninferiority; P = 0.02 for superiority).

Number Needed to treat for Primary Outcome = 224

• Although not statistically significant, the results also showed a possible benefit from canagliflozin with respect to the progression of albuminuria (hazard ratio, 0.73; 95% CI, 0.67 to 0.79) and the composite outcome of a sustained 40% reduction in the eGFR, the need for renal-replacement therapy, or death from renal causes (hazard ratio, 0.60; 95% CI, 0.47 to 0.77.)
• Credence Renal Trial stopped early in July 2018 due to positive outcomes.

https://www.jnj.com/phase-3-credence-renal-outcomes-trial-of-invokana-canagliflozin-is-being-stopped-early-for-positive-efficacy-findings
• Inclusion Criteria
  • Type 2 DM
  • Age ≥30 yr
  • A1c ≥ 6.5% to ≤ 12% (≥ 6.5% to ≤ 10.5% in Germany)
  • Kidney disease in the setting of T2DM
    • Absence of alternative diagnosis to account for kidney pathology
  • Estimated GFR ≥ 30 to < 90 mL/min/1.73m²
  • Albuminuria: defined as urine albumin:creatinine ratio [UACR] 300 to 5,000 mg/g
  • Goal was to enroll 60% of the patient population with stage 3 CKD with eGFR of ≥ 30 to < 60 mL/min/1.73m² at study entry.
  • Patients were required to be on maximum labeled or tolerated dose of ACEi or ARB for ≥ 4 weeks prior to randomization.
    • Combination of ACE/ARB/direct renin inhibitor was not allowed
• Selected exclusion criteria: past use of a SGLT-2i within 12 weeks, or randomization, current or past participation in another canagliflozin study
• Canagliflozin 100 mg orally once daily
• Primary Endpoint
  • Composite of end-stage kidney disease, doubling of SCr, and renal or CVD death
• Enrollment was 4,401
  • Mean duration of T2DM was 15.8 yr
  • Mean A1c of 8.3%
  • Mean baseline eGFR was 56.2 mL/min/1.73m²
  • Median UACR was 927 mg/g
• No CV history inclusion requirement

CV death or hospitalized HF was reduced in those treated with canagliflozin compared with placebo (16.3 versus 20.8 per 1000 patient-years; hazard ratio [HR], 0.78; 95% confidence interval [CI], 0.67–0.91)

In addition, fatal or hospitalized HF (HR, 0.70; 95% CI, 0.55–0.89) and hospitalized HF alone (HR, 0.67; 95% CI, 0.52–0.87) were also reduced.

The benefit for CV death or hospitalized HF may be greater in patients with a prior history of HF (HR, 0.61; 95% CI, 0.46–0.80) compared with those without HF at baseline (HR, 0.87; 95% CI, 0.72–1.06; P interaction =0.021).

DECLARE - TIMI 58 (dapagliflozin)

Type 2 DM >40 y/o who had or were at high risk for ASCVD. Multicenter, randomized, double blind, placebo-controlled.

Primary Safety Outcome: 3 point MACE CV death, MI, stroke; Efficacy outcomes added a composite of CV death or hospitalization for HF.

Non-inferior for safety outcome  P<0.001
No difference in MACE for efficacy, (8.8% in the dapagliflozin group and 9.4% in the placebo group; hazard ratio, 0.93; 95% CI, 0.84 to 1.03; P=0.17).

NNT for primary outcome= 166

• Dapagliflozin did result in a lower rate of cardiovascular death or hospitalization for heart failure (4.9% vs. 5.8%; hazard ratio, 0.83; 95% CI, 0.73 to 0.95; P=0.005), which reflected a lower rate of hospitalization for heart failure (hazard ratio, 0.73; 95% CI, 0.61 to 0.88);
  • There was no between-group difference in cardiovascular death (hazard ratio, 0.98; 95% CI, 0.82 to 1.17).

• AstraZeneca also announced a new CVOT trial- DELIVER
  • Will look at SGLT-2i in patients with HF (reduced EF)

Trial Comparisons

• Major differences were inclusion criteria.
  • CANVAS and DECLARE-TIMI 58 were primary and secondary prevention
  • This broader population in CANVAS likely influenced the higher number needed to treat than EMPA-Reg, as well as the lack of difference in MACE in DECLARE-TIMI58
  • In the CANVAS trial, adverse reactions were consistent with the previously reported risks associated with canagliflozin except for an increased risk of amputation (6.3 vs. 3.4 participants per 1000 patient-years; hazard ratio, 1.97; 95% CI, 1.41 to 2.75); amputations were primarily at the level of the toe or metatarsal.

Amputations SGLT-2i vs. DPP-4i

• Active comparator study
• New user cohort
• 30,216 comparable patients in each arm
• After 0.6 years of follow-up, 60 amputations: 36 SGLT-2i, 25 DPP-4i
  • Most at the level of the partial foot (75%) and associated with diabetes-related vascular disease (66.7%)
• The incidence of amputations was higher among SGLT-2i patients with a HR 1.38 (CI: 0.83-2.31)
• Subgroup analyses, risk differed by SGLT-2i
  • Canagliflozin HR 1.15 (CI 0.63-2.09); dapagliflozin or empagliflozin HR 2.25 (CI 0.78-6.47).
• Risk of amputations was higher with SGLT-2is than DPP-4is but difference was not significant

**OBSERVE-4D**

- Large comprehensive real-world observational study of below-knee lower extremity (BKLE) amputation and hospitalization for heart failure (HHF)
- HR estimate for canagliflozin vs. non-SGLT-2i
  - 0.39 (95% CI, 0.26-0.60) for HHF
  - 0.75 (95% CI, 0.40-1.41) for BKLE amputation
- Effects in subpopulation with established CV disease were similar for both outcomes
- No consistent differences observed between canagliflozin and other SGLT-2i

The CVD-REAL (Comparative Effectiveness of Cardiovascular Outcomes in New Users of SGLT-2 Inhibitors) study was a multinational, observational study of adults with T2DM.

Patients prescribed an SGLT-2i or other glucose-lowering drugs (GLDs) were matched based on a propensity score for initiation of an SGLT-2i.

Hazard ratios (HRs) for the risk of death, HF, and HF or death in patients with and without established CVD were estimated for each country and pooled.

After propensity score matching, 153,078 patients were included in each group. At baseline, 13% had established CVD.

Compared with therapy using other GLDs, initiation of an SGLT-2i was associated with lower risk of death in patients with and without CVD (HR: 0.56; 95% confidence interval [CI]: 0.44 to 0.70; and HR: 0.56; 95% CI: 0.50 to 0.63, respectively).

There were also associations between SGLT-2i and lower risk of HF (HR: 0.72; 95% CI: 0.63 to 0.82; and HR: 0.61; 95% CI: 0.48 to 0.78, respectively) and the composite of HF or death (HR: 0.63; 95% CI: 0.57 to 0.70; and HR: 0.56; 95% CI: 0.50 to 0.62, respectively) observed in patients with and without established CVD.

Meta-Analysis of SGLT-2 in CVOTs

• SGLT-2 inhibitors collectively reduced major cardiovascular events by 11% in patients with previous disease.

• SGLT2i reduced the risk of cardiovascular death or hospitalizations for heart failure by 23% (0.77 [0.71–0.84], p<0.0001), with a similar benefit in patients with and without atherosclerotic cardiovascular disease and with and without a history of heart failure.

• SGLT2i reduced the risk of progression of renal disease by 45% (0.55 [0.48–0.64], p<0.0001), with a similar benefit in those with and without atherosclerotic cardiovascular disease.

• Robust reductions in hospitalization for heart failure and progression of renal disease are seen regardless of baseline atherosclerotic risk category or a history of heart failure.

SGLT-2i in DM + CHF Risk

- SGLT-2i drugs showed the largest reduction for heart failure risk (RR 0.56, 95% CI 0.43-0.72) versus other medications for type 2 diabetes when compared with placebo.

- A pooled analysis restricted to the trials only assessing SGLT-2i showed a similar significant reduction in the risk of hospitalization for heart failure when compared with placebo (RR 0.56, 95% CI 0.41-0.77, $P=0.067$, $I^2=70.2\%$).
  - Not seen with GLP-1 RA or DPP-4i analysis.

- The researchers also found no significant association between heart failure risk in these trial participants with a lowering of A1c over time, measured with a meta-regression analysis.

Kramer C et al. JACC Heart Fai. 2018, published online https://doi.org/10.1016/j.jchf.2018.05.021.
SGLT-2i for CV Benefits Outside of DM

• In a comparison of dapagliflozin vs. bumetanide in CHF\(^1\)
  • Dapagliflozin had little impact on circulating blood volume
  • More impact on interstitial edema

• Noted effects of SGLT-2i beyond glucose lowering\(^2\)
  • Improvement in ventricular loading conditions through a reduction in preload and afterload
  • Improvement in cardiac metabolism and bioenergetics
  • Myocardial Na+/H+ exchange inhibition- direct myocardium effects
  • Reduction of necrosis and cardiac fibrosis
  • Alteration in adipokines, cytokine production, and epicardial adipose tissue mass

• Baseline and time-dependent changes in A1c, blood pressure, and cholesterol do not seem to determine the overall benefit of SGLT-2i on cardiovascular outcomes.

PT, a 61-year-old female with T2DM, CAD (unstable angina), and CHF reports to your clinic today for diabetes management.
Current A1c is 8.7%, BP is 130/82 mm Hg
Physical Exam Today: Noted 1+ Pitting Edema bilateral lower extremities
CGM profile shows her BG often gets down to 55-60’s overnight and spikes to 300’s after meals
CMP WNL
Current Therapy
- metformin 1,000 mg orally twice daily
- insulin glargine 80 units SC daily
- insulin lispro 15 units SC with meals (often forgets to take)
- ASA 325 mg orally daily
- metoprolol tartrate 50 mg orally twice daily
- atorvastatin 80 mg orally daily
- furosemide 20 mg orally daily
- spironolactone 25 mg orally daily
Which of the following medications would be most appropriate to add to metformin in PT based on current treatment guidelines and recent evidence of efficacy for patients with comorbidities like hers?

a) Sitagliptin  
b) Liraglutide  
c) Empagliflozin  
d) Acarbose
Question 8

Based on PT’s other medications, what side effect would be most important to monitor for?

a) Volume depletion
b) Hyperkalemia
c) Hypoglycemia
d) Bradycardia
Current Guidelines for Management of T2DM
AACE/ACE Lifestyle Therapy

Nutrition

Smoking cessation

Physical activity

Behavioral support

Sleep

AACE/ACE Algorithm: Beyond Lifestyle

<table>
<thead>
<tr>
<th>A1C &lt; 7.5%: Monotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
</tr>
<tr>
<td>GLP-1 RA</td>
</tr>
<tr>
<td>SGLT-2i</td>
</tr>
<tr>
<td>DPP-4i</td>
</tr>
<tr>
<td>TZD – use with caution</td>
</tr>
<tr>
<td>AGi</td>
</tr>
<tr>
<td>SU/GLN – use with caution</td>
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</table>

<table>
<thead>
<tr>
<th>A1C ≥ 7.5%: Metformin +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual therapy or Triple therapy</td>
</tr>
<tr>
<td>Same ordered preference list</td>
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<table>
<thead>
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<th>A1C &gt; 9%</th>
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<tr>
<td>Symptomatic</td>
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<tr>
<td>Insulin + other agents</td>
</tr>
<tr>
<td>Asymptomatic</td>
</tr>
<tr>
<td>Dual or triple therapy</td>
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</tbody>
</table>

In order of preference

AACE/ACE Considerations for Therapy Selection

- Risk of hypoglycemia
- Impact on weight
- Renal/genitourinary effects
- GI symptoms
- Cardiac effects
  - ASCVD
  - CHF
- Bone impact
- Potential to cause ketoacidosis

Antihyperglycemic Therapy in Adults with Type 2 Diabetes

At diagnosis, initiate lifestyle management, set A1C target, and initiate pharmacologic therapy based on A1C:

- A1C is less than 9%, consider Monotherapy.
- A1C is greater than or equal to 9%, consider Dual Therapy.
- A1C is greater than or equal to 10%, blood glucose is greater than or equal to 300 mg/dL, or patient is markedly symptomatic, consider Combination Injectable Therapy (See Figure 8.2).

Monotherapy

Lifestyle Management + Metformin

Initiate metformin therapy if no contraindications* (See Table 8.1)

- A1C at target after 3 months of monotherapy?
  - Yes: - Monitor A1C every 3–6 months
  - No: - Assess medication-taking behavior
    - Consider Dual Therapy

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Dual Therapy

Lifestyle Management + Metformin + Additional Agent

ASCVD?

Yes:  - Add agent proven to reduce major adverse cardiovascular events and/or cardiovascular mortality (see recommendations with * on p. S75 and Table 8.1)

No:   - Add second agent after consideration of drug-specific effects and patient factors (See Table 8.1)

A1C at target after 3 months of dual therapy?

Yes:  - Monitor A1C every 3–6 months

No:   - Assess medication-taking behavior
      - Consider Triple Therapy

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## ADA Guidelines- CV Guidance

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>ASCVD</th>
<th>CHF</th>
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</thead>
<tbody>
<tr>
<td>SGLT-2 Inhibitors (SGLT-2i)</td>
<td>Benefit: canagliflozin, empagliflozin</td>
<td>Benefit: canagliflozin, empagliflozin</td>
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<tr>
<td>GLP-1 receptor agonists (GLP-1 RA)</td>
<td>Neutral: lixisenatide, exenatide ER, dulaglutide</td>
<td>Neutral</td>
</tr>
<tr>
<td></td>
<td>Benefit: liraglutide, Semaglutide, albiglutide*</td>
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<tr>
<td>DPP-4 Inhibitors (DPP-4i)</td>
<td>Neutral</td>
<td>Potential Risk: saxagliptin, alogliptin</td>
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<tr>
<td>TZD</td>
<td>Potential Benefit: Pioglitazone</td>
<td>Increased Risk</td>
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</tbody>
</table>

*off market in US

Modified from Table 8.1 American Diabetes Association. *Diabetes Care.* 2018;41(Suppl. 1):S1–S159.
## ADA Guidelines- CV Guidance (cont.)

<table>
<thead>
<tr>
<th>Drug</th>
<th>ASCVD</th>
<th>CHF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sulfonylureas (SU)</td>
<td>Neutral</td>
<td>Neutral</td>
</tr>
<tr>
<td>Metformin</td>
<td>Potential Benefit</td>
<td>Neutral</td>
</tr>
<tr>
<td>Insulin</td>
<td>Neutral</td>
<td>Neutral</td>
</tr>
</tbody>
</table>

Modified from Table 8.1 American Diabetes Association. *Diabetes Care.* 2018;41(Suppl. 1):S1–S159.
ADA Guidelines

Figure 8.1—Antihyperglycemic therapy in type 2 diabetes: general recommendations. *If patient does not tolerate or has contraindications to metformin, consider agents from another class in Table 8.1. #GLP-1 receptor agonists and DPP-4 inhibitors should not be prescribed in combination. If a patient with ASCVD is not yet on an agent with evidence of cardiovascular risk reduction, consider adding.

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• Assess ASCVD status first!
• Lifestyle modification and metformin are still considered the cornerstones of treatment
• ASCVD predominates
  • GLP-1 RA with proven CVD benefit or SGLT-2i with proven CVD benefit
• Heart failure or CKD predominates:
  • Listed first is a SGLT-2i with evidence of reducing heart failure or CKD progression in a cardiovascular outcomes trial (if the patient has adequate kidney function), with a GLP-1 RA with proven CVD benefit as an alternative option.
ADA & EASD 2018 Consensus Report: Dual-Therapy

Choose agents with evidence of benefit in all categories

Metformin + lifestyle

Established ASCVD or CKD

ASCVD
- GLP-1 RA or SGLT-2i

HF or CKD
- SGLT-2i

ADA & EASD 2018 Consensus Report: Dual-Therapy

Choose agents with evidence of benefit in all categories

- Metformin + lifestyle

  Established ASCVD or CKD
    - ASCVD
      - GLP-1 RA or SGLT-2i
    - HF or CKD
      - SGLT-2i
    - Compelling need to minimize hypoglycemia
      - DPP-4i or GLP-1 RA or SGLT-2i or TZD

  Without established ASCVD or CKD
    - Compelling need to minimize weight gain OR promote weight loss
      - GLP-1 RA or SGLT-2i
    - Cost is primary concern
      - SU or TZD

• If A1c 1.5% above individualized goal, early combination therapy is warranted
• Patients without ASCVD
  • Focus on agents that promote weight loss in overweight patients
  • First line still metformin then SGLT-2i or GLP-1 RA
• Minimize hypoglycemia
  • Metformin first, then GLP-1 RA or SGLT-2i or TZD or DPP-4i
• If cost is a MAJOR issue
  • SU or TZD, then consider lowest cost basal insulin or DPP-4i or SGLT-2i

ACC Decision Pathway

- Provides guidance to prescribers to look at these medications for CV benefit in patients with established ASCVD
  - Not enough evidence to recommend for at risk patients
- Similar recommendations to other guidelines regarding using a GLP-1 RA or SGLT-2i with proven CVD benefit.
- Pathway preferences liraglutide for GLP-1 RA and empagliflozin for SGLT-2i. (*note dapagliflozin data is not included in the report*)

Revisit CJ

- 55-year-old African American male with a history of CABG x 3
- Type 2 DM x 15 years
- HTN
- Hyperlipidemia (high TG and LDL)

- Current medications include:
  - clopidogrel 75 mg orally daily
  - ASA 325 mg orally daily
  - metformin 1,000 mg orally twice daily
  - glipizide 5 mg orally twice daily
  - lisinopril/HCTZ 20-12.5, two tablets orally daily
  - metoprolol 25 mg ER orally daily
  - atorvastatin 40 mg orally daily
Revisit CJ

- Height 5’9"
- Weight 260 lb
- BMI: 38.4 kg/m²

- BP today is 145/87 mm Hg, Pulse of 62 bpm

- Today CJ is here for follow-up for his diabetes. A1c is 9.5%, other labs are WNL, including renal function.

- During your initial review of systems with CJ you learn that his blood glucose levels are fluctuating anywhere from 55 to 400 mg/dL in a given day.

- He also reports that he stopped metformin due to daily diarrhea even with the extended release version.
Question 9

Based on the current treatment guidelines what type of treatment would be recommended for CJ?

a) Dual Therapy (SGLT-2i & GLP-1 RA)
b) Dual Therapy (GLP-1 RA & Insulin)
c) GLP-1 RA Monotherapy
d) Basal Insulin Monotherapy
Which of the following medications would you recommend to reduce CJ's A1c to less than 6.5% based on current treatment guidelines?

a) Dapagliflozin 10 mg daily + liraglutide 1.8 mg daily  
b) Empagliflozin 25 mg daily + exenatide 2 mg once weekly  
c) Empagliflozin 25 mg daily + liraglutide 1.8 mg daily  
d) Dapagliflozin 10 mg daily + dulaglutide 1.5 mg once weekly
Strategies for Identifying and Integrating New CVOT Literature Into Practice
Overall Comparison of Medications

Mechanism of action

Patient-specific Choice

Administration – route and schedule

Efficacy

ASCVD Risk

Safety/tolerability
T2DM Pharmacotherapy Approach in 2018

1st – Assess CVD risk

Metformin + lifestyle modifications

Determine addition of dual or triple therapy based on ASCVD risk

T2DM Pharmacotherapy Approach in 2018: ASCVD Risk

GLP-1 RA  OR  SGLT-2i

What will ongoing studies show?

Garber AL et al. *Endocr Pract*. 2018; 24:91-120
According to the 2018 American Association of Clinical Endocrinologist (AACE) and ADA/EASD recommendations for managing patients with T2DM, what factor is the FIRST consideration for which therapy should be added after lifestyle modifications and metformin?

a) Route of administration

b) ASCVD risk status

c) Mechanism of action

d) Safety
1) The benefits of antidiabetic therapy beyond A1c lowering effects allow for individualized selection of therapy.

2) Based on guidelines and cardiovascular outcome clinical trials (CVOT), patients with established ASCVD or at high risk of CVD should receive GLP-1 RA or SGLT-2i with proven benefit in these patient populations.

3) Being aware of CVOT that are recently completed or scheduled for completion in the near future will help you stay up-to-date with primary literature.

4) Guidelines for management of T2DM are updated as new clinical trial results become available, so monitoring for new evidence-based guidelines and study reports on a routine basis can optimize patient care.
Questions?