GLP-1RAs: Evidence from the real world

Springer Healthcare IME

GLP-1RAs: Evidence from the real world

CME Accredited

Live webinar

Don't miss out on this **ACCME accredited live webinar** broadcast from Busan, Korea on 5th December 2019, chaired by Professor Melanie Davies from the University of Leicester, UK.

This interactive webinar will include 4 case-based presentations from experts across Europe, Canada, Japan and Brazil focusing on current guideline recommendations and **real-world evidence of new and emerging GLP-1RAs**.

For further information and to register, please visit
http://bit.ly/Real_World_GLP-1RAs

eLearning modules

Four 15-minute eLearning modules based on the case-based presentations from the webinar will be available in early 2020.

The cases will feature learner interactivity throughout with pre- and post-assessment questions included to measure changes in knowledge.

For more information, please visit
http://bit.ly/Real_World_GLP-1RAs

Accreditation

The above activities have been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Imedex and Springer Healthcare IME. Imedex is accredited by the ACCME to provide continuing medical education for physicians.

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Educational grant

This program is made possible thanks to an independent educational grant from Novo Nordisk A/S.

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Introduction

Clinical inertia (failure to intensify treatment when treatment targets are not met) contributes to diabetes progression and complications. One reason for clinical inertia is physicians not knowing how to intensify treatment given the complexity of available treatment options today. Physicians need practical, evidence-based guidance on giving the right treatment at the right time to the right patient.

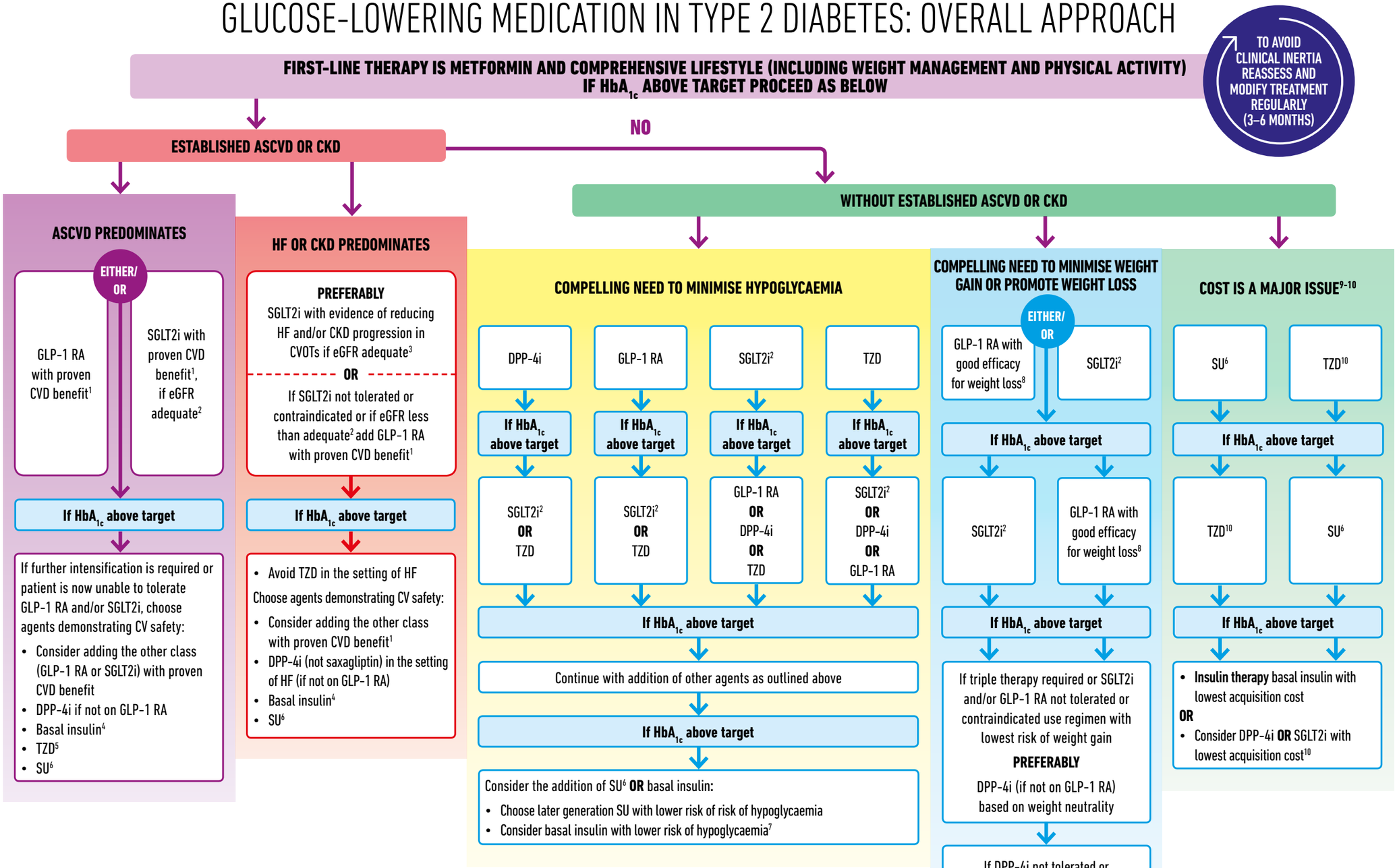
The recent ADA/EASD consensus report provides this guidance and recommends earlier use of specific GLP-1RAs and SGLT2 inhibitors, particularly in patients with established cardiovascular or renal disease. There is a need to reinforce the importance and implications of this consensus for physicians worldwide with respect to their local healthcare systems.

A lack of time and unfamiliarity with the efficacy and safety of these medications may mean that conventional regimens (e.g. metformin and sulfonylureas) are more commonly prescribed, while these new options with potentially greater efficacy and cardiovascular benefits are overlooked.

This booklet features key infographics, reproduced with permission from *Diabetologia*, offering diabetes physicians direct access to these valuable, visual and easy-to-use clinical decision-making resources.

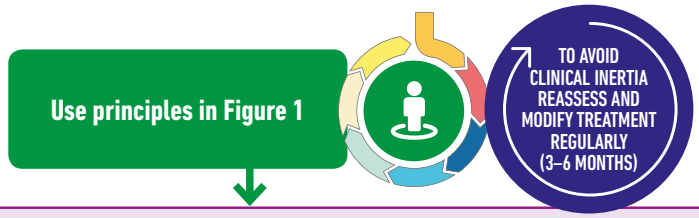
Figure 1

GLUCOSE-LOWERING MEDICATION IN TYPE 2 DIABETES: OVERALL APPROACH



1. Proven CVD benefit means it has label indication of reducing CVD events. For GLP-1 RA strongest evidence of liraglutide > semaglutide > exenatide. For SGLT2i evidence modestly stronger for empagliflozin > canagliflozin.
2. Be aware that SGLT2i vary by region and individual agent with regard to indicated level of eGFR for initiation and continued use
3. Both empagliflozin and canagliflozin have shown reduction in HF and reduction in CKD progression in CVOTs
4. Degludec or U100 glargine have demonstrated CVD safety
5. Low dose may be better tolerated though less well studied for CVD effects
6. Choose later generation SU with lower risk of hypoglycaemia
7. Degludec / glargine U300 < glargine U100 / detemir < NPH insulin
8. Semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide
9. If no specific comorbidities (i.e. no established CVD, low risk of hypoglycaemia and lower priority to avoid weight gain or no weight related comorbidities)
10. Consider country- and region-specific cost of drugs. In some countries TZDs relatively more expensive and DPP-4i relatively cheaper

Figure 2 CHOOSING GLUCOSE-LOWERING MEDICATION IN THOSE WITH ESTABLISHED ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) OR CHRONIC KIDNEY DISEASE (CKD)



Use metformin unless contraindicated or not tolerated

If not at HbA_{1c} target:

- Continue metformin unless contraindicated (remember to adjust dose/stop metformin with declining eGFR)
- Add SGLT2i or GLP-1 RA with proven cardiovascular benefit[1] (See below)

If at HbA_{1c} target:

- If already on dual therapy, or multiple glucose-lowering therapies and not on an SGLT2i or GLP-1 RA, consider switch to one of these agents with proven cardiovascular benefit[1] (See below)

OR reconsider/lower individualised target and introduce SGLT2i or GLP-1 RA

OR reassess HbA_{1c} at 3 month intervals and add SGLT2i or GLP-1 RA if HbA_{1c} goes above target

ASCVD predominates

GLP-1 RA with proven CVD benefit[1]

EITHER/ OR

SGLT2i with proven CVD benefit[1], if eGFR adequate[2]

If HbA_{1c} above target

If further intensification is required or patient is unable to tolerate GLP-1 RA and/or SGLT2i, choose agents demonstrating CV safety:

- Consider adding the other class (GLP-1 RA or SGLT2i) with proven CVD benefit[1]
- DPP-4i if not on GLP-1 RA
- Basal insulin[5]
- TZD[6]
- SU[7]

HF or CKD predominates

PREFERABLY
SGLT2i with evidence of reducing HF and/or CKD progression in CVOTs if eGFR adequate[3]

OR

If SGLT2i not tolerated or contraindicated or if eGFR less than adequate[2] add GLP-1 RA with proven CVD benefit[1,4]

If HbA_{1c} above target

- Avoid TZD in the setting of HF

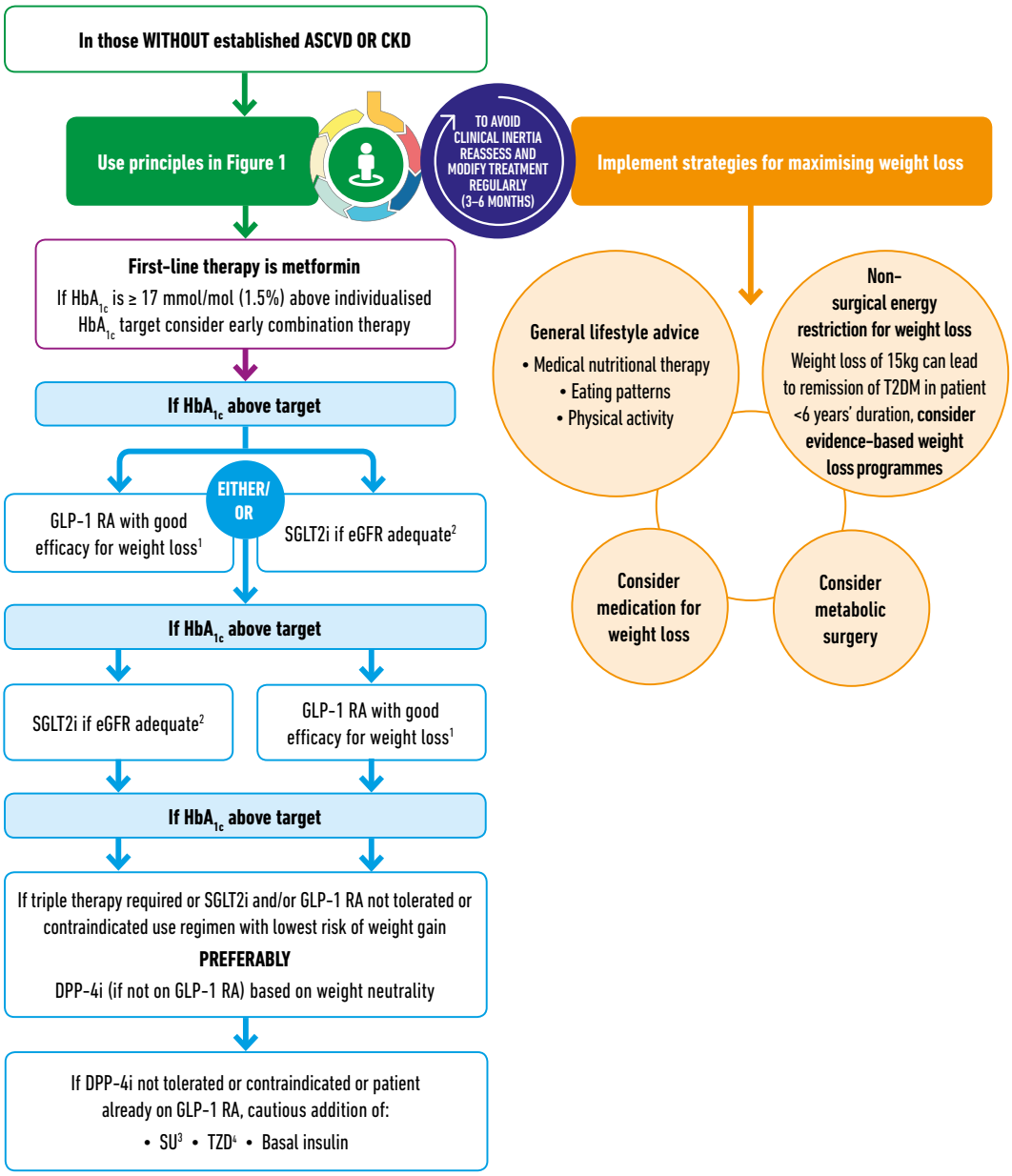
Choose agents demonstrating CV safety:

- Consider adding the other class with proven CVD benefit[1]
- DPP-4i (not saxagliptin) in the setting of HF (if not on GLP-1 RA)
- Basal insulin[5]
- SU[7]

1. Proven CVD benefit means it has label indication of reducing CVD events. For GLP-1 RA strongest evidence of liraglutide > semaglutide > exenatide. For SGLT2i evidence modestly stronger for empagliflozin > canagliflozin.
2. Be aware that SGLT2i vary by region and individual agent with regard to indicated level of eGFR for initiation and continued use
3. Caution with GLP-1 RA in ESRD
4. Both empagliflozin and canagliflozin have shown reduction in HF and to reduce CKD progression in CVOT trials
5. Degludec or U100 glargine have demonstrated CVD safety
6. Low dose may be better tolerated though less well studied for CVD effects
7. Choose later generation SU to lower risk of hypoglycaemia

Figure 3

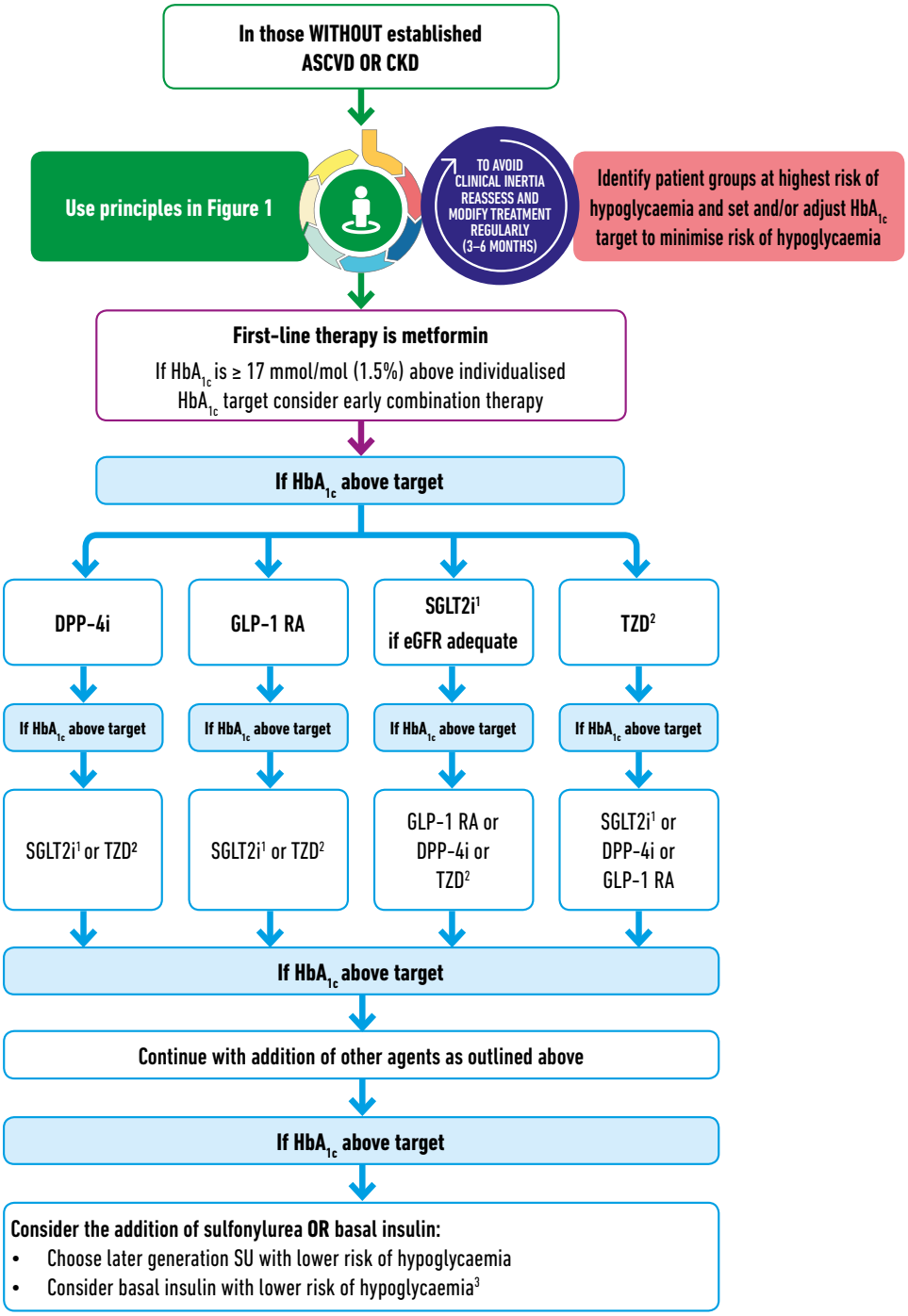
CHOOSING GLUCOSE-LOWERING MEDICATION IF COMPELLING NEED TO MINIMISE WEIGHT GAIN OR PROMOTE WEIGHT LOSS



1. Semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide
2. Be aware that SGLT2i vary by region and individual agent with regard to indicated level of eGFR for initiation and continued use
3. Choose later generation SU with lower risk of hypoglycaemia
4. Low dose may be better tolerated though less well studied for CVD effects

Figure 4

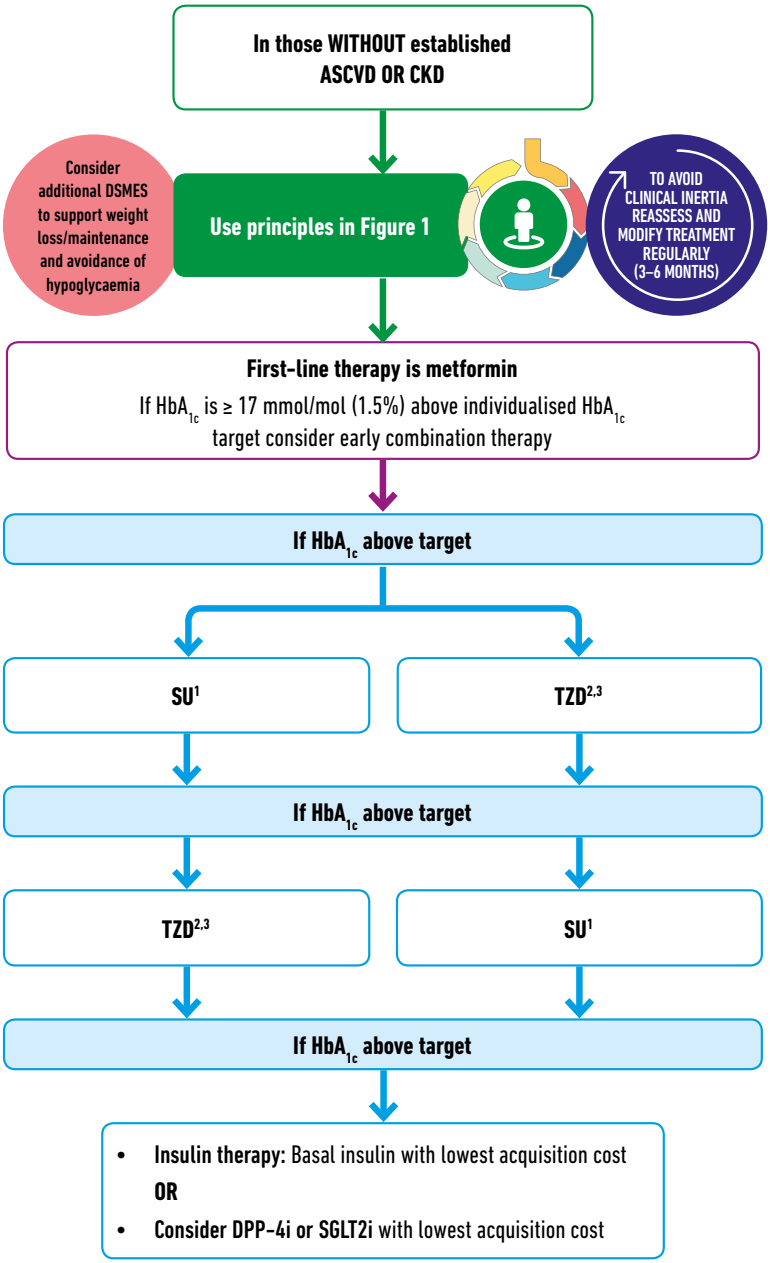
CHOOSING GLUCOSE-LOWERING MEDICATION IF COMPELLING NEED TO MINIMISE HYPOGLYCAEMIA



1. Be aware that SGLT2i vary by region and individual agent with regard to indicated level of eGFR for initiation and continued use
2. Low dose TZDs are better tolerated
3. Degludec / glargine U300 < glargine U100 / detemir < NPH insulin

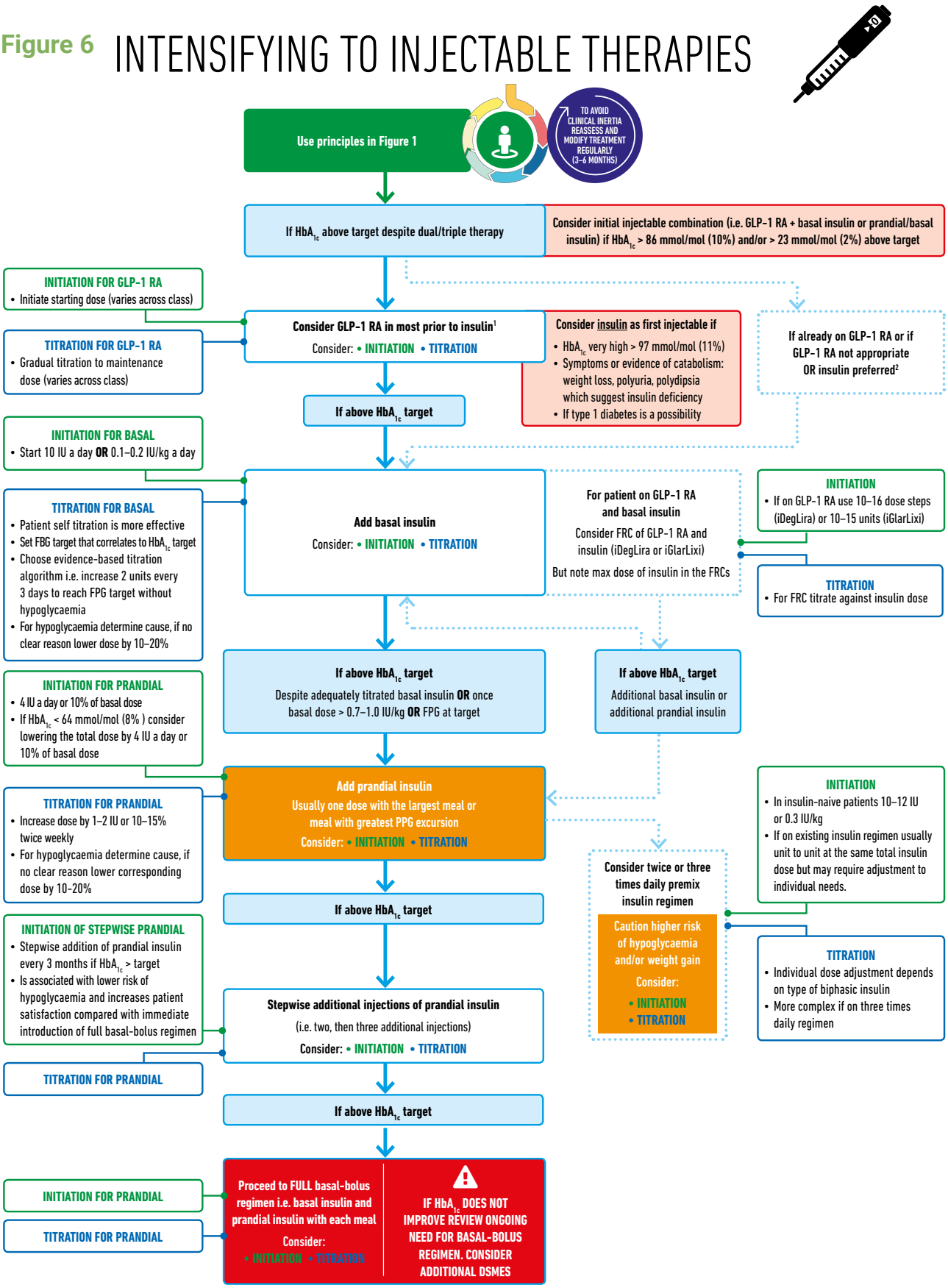
Figure 5

CHOOSING GLUCOSE-LOWERING MEDICATION IF COST IS A MAJOR ISSUE

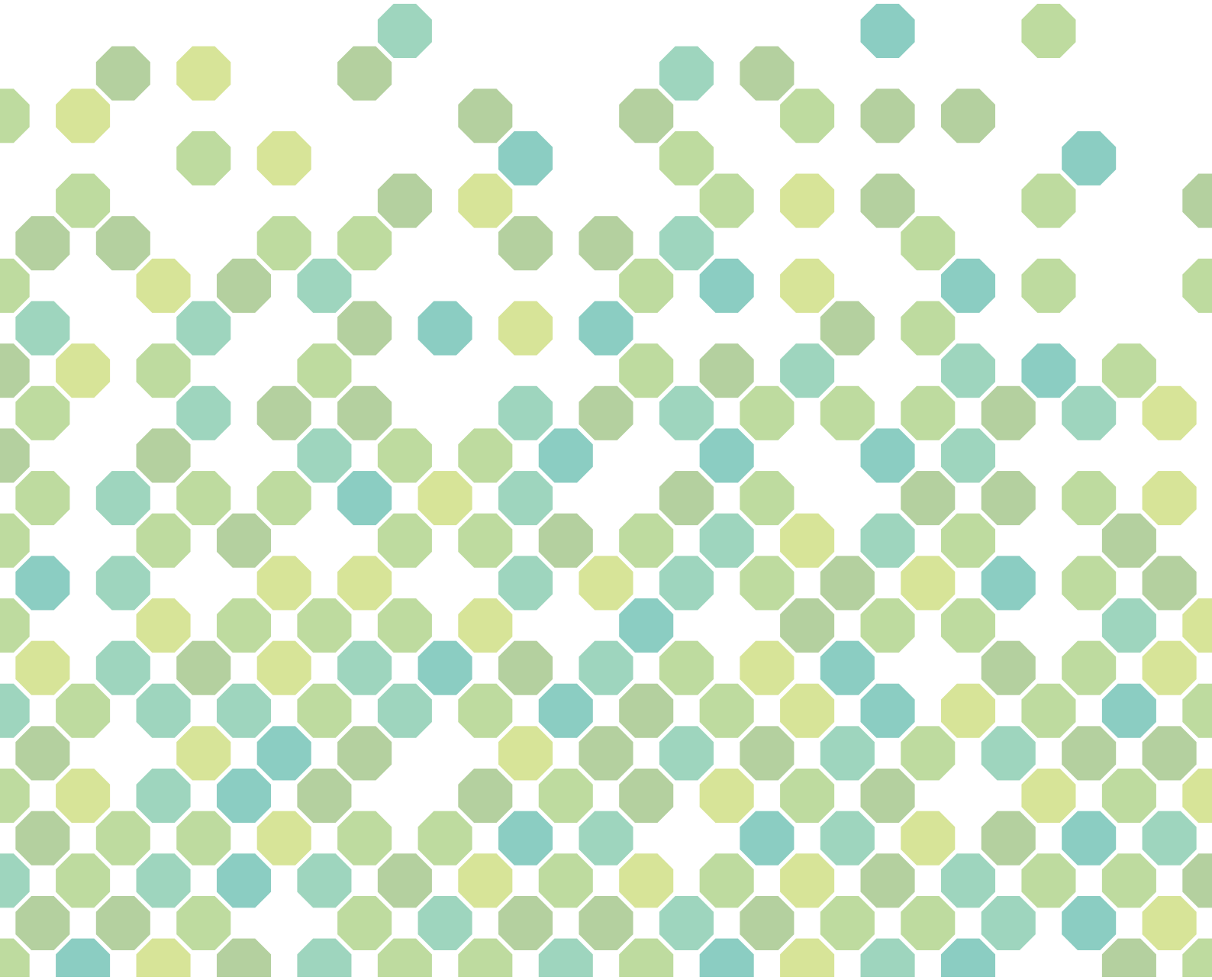


1. Choose later generation SU to minimise risk of hypoglycaemia
2. Consider country- and region-specific cost of drugs. In some countries, TZD relatively more expensive and DPP-4i relatively cheaper
3. Low-dose TZDs are better tolerated

Figure 6 INTENSIFYING TO INJECTABLE THERAPIES



1. Consider choice of GLP-1 RA considering: patient preference, HbA_{1c} lowering, weight-lowering effect or frequency of injection. If CVD, consider GLP-1 RA with proven CVD benefit
2. Consider insulin as preferred to GLP-1 RA if symptoms of hyperglycaemia are present, or evidence of ongoing catabolism (polyuria, polydipsia or weight loss)



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