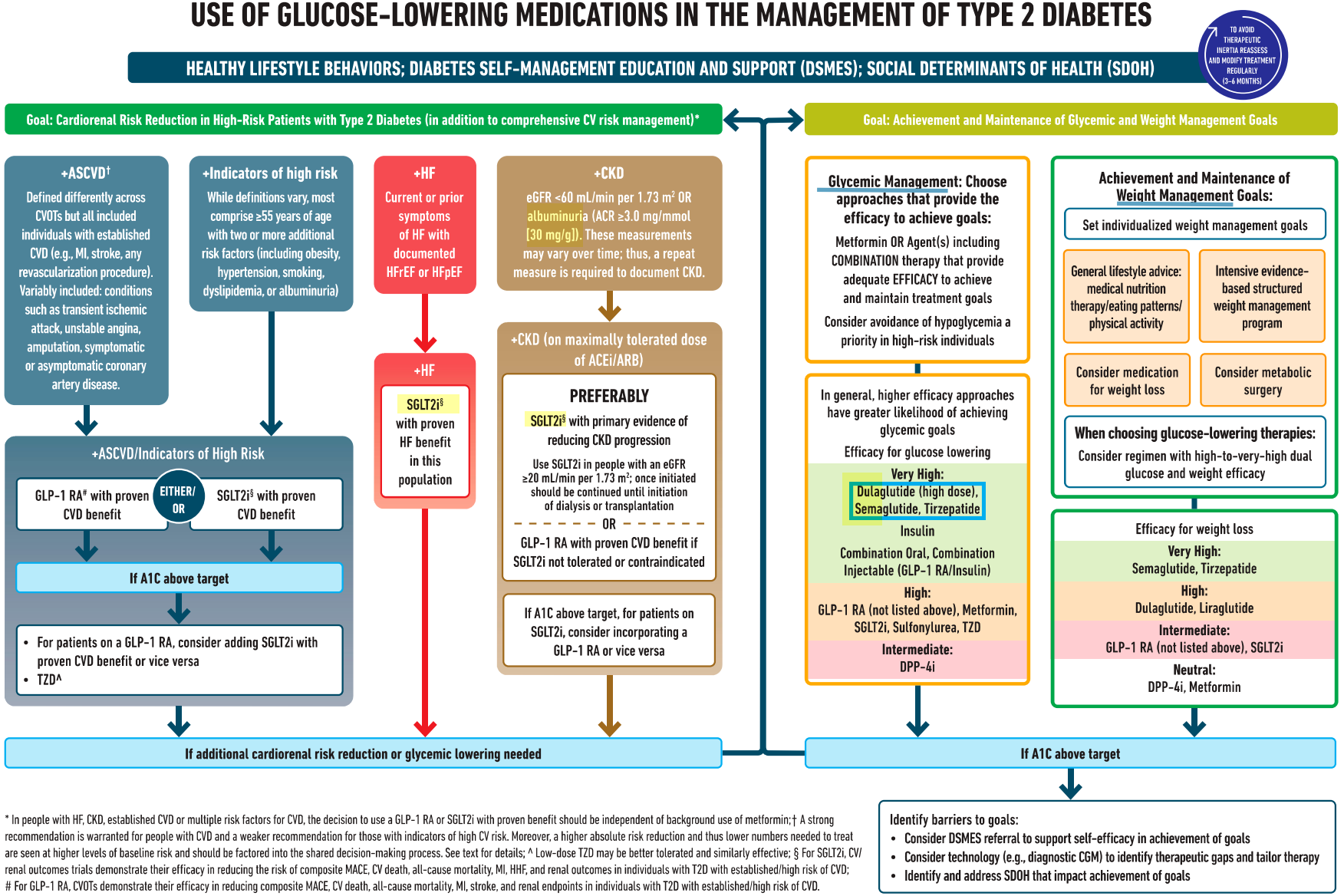
USE OF GLUCOSE-LOWERING MEDICATIONS IN THE MANAGEMENT OF TYPE 2 DIABETES



* In people with HF, CKD, established CVD or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be independent of background use of metformin;† A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high CV risk. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details; ^ Low-dose TZD may be better tolerated and similarly effective; § For SGLT2i, CV/renal outcomes trials demonstrate their efficacy in reducing the risk of composite MACE, CV death, all-cause mortality, MI, HHF, and renal outcomes in individuals with T2D with established/high risk of CVD; # For GLP-1 RA, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and renal endpoints in individuals with T2D with established/high risk of CVD.

FIGURE 9.3 Use of glucose-lowering medications in the management of type 2 diabetes. ACEi, ACE inhibitor; ACR, albumin-to-creatinine ratio; CVOT, cardiovascular outcomes trial; DPP-4i, dipeptidyl peptidase 4 inhibitor; GLP-1 RA, glucagon-like peptide 1 receptor agonist; HHF, hospitalization for heart failure; SGLT2i, sodium-glucose cotransporter 2 inhibitor; T2D, type 2 diabetes. Adapted from Davies MJ, Aroda VR, Collins BS, et al. Diabetes Care 2022;45:2753–2786.

TABLE 9.2 Medications for Lowering Glucose, Summary of Characteristics

	Efficacy[1]	Hypoglycemia	Weight change[2]	CV effects		Renal effects		Oral/SQ	Cost	Clinical considerations
				Effect on MACE	HF	Progression of DKD	Dosing/use considerations*			
Metformin	High	No	Neutral (potential for modest loss)	Potential benefit	Neutral	Neutral	• Contraindicated with eGFR <30 mL/min per 1.73 m^2	Oral	Low	• GI side effects common; to mitigate GI side effects, consider slow dose titration, extended release formulations, and administration with food • Potential for vitamin B12 deficiency; monitor at regular intervals
SGLT2 inhibitors	Intermediate to high	No	Loss (intermediate)	Benefit: canagliflozin, empagliflozin	Benefit: canagliflozin, dapagliflozin, empagliflozin, ertugliflozin	Benefit: canagliflozin, dapagliflozin, empagliflozin	• See labels for renal dose considerations of individual agents • Glucose-lowering effect is lower for SGLT2 inhibitors at lower eGFR	Oral	High	• DKA risk, rare in T2DM: discontinue, evaluate, and treat promptly if suspected; be aware of predisposing risk factors and clinical presentation (including euglycemic DKA); discontinue before scheduled surgery (e.g., 3–4 days), during critical illness, or during prolonged fasting to mitigate potential risk • Increased risk of genital mycotic infections • Necrotizing fasciitis of the perineum (Fournier gangrene), rare reports: institute prompt treatment if suspected • Attention to volume status, blood pressure; adjust other volume-contracting agents as applicable
GLP-1 RAs	High to very high	No	Loss (intermediate to very high)	Benefit: dulaglutide, liraglutide, semaglutide (SQ) Neutral: exenatide once weekly, lixisenatide	Neutral	Benefit for renal endpoints in CVOTs, driven by albuminuria outcomes: dulaglutide, liraglutide, semaglutide (SQ)	• See labels for renal dose considerations of individual agents • No dose adjustment for dulaglutide, liraglutide, semaglutide • Monitor renal function when initiating or escalating doses in patients with renal impairment reporting severe adverse GI reactions	SQ; oral (semaglutide)	High	• Risk of thyroid C-cell tumors in rodents; human relevance not determined (liraglutide, dulaglutide, exenatide extended release, semaglutide) • Counsel patients on potential for GI side effects and their typically temporary nature; provide guidance on dietary modifications to mitigate GI side effects (reduction in meal size, mindful eating practices [e.g., stop eating once full], decreasing intake of high-fat or spicy food); consider slower dose titration for patients experiencing GI challenges • Pancreatitis has been reported in clinical trials but causality has not been established. Discontinue if pancreatitis is suspected • Evaluate for gallbladder disease if cholelithiasis or cholecystitis is suspected
GIP and GLP-1 RA	Very high	No	Loss (very high)	Under investigation	Under investigation	Under investigation	• See label for renal dose considerations • No dose adjustment • Monitor renal function when initiating or escalating doses in patients with renal impairment reporting severe adverse GI reactions	SQ	High	• Risk of thyroid C-cell tumors in rodents; human relevance not determined • Counsel patients on potential for GI side effects and their typically temporary nature; provide guidance on dietary modifications to mitigate GI side effects (reduction in meal size, mindful eating practices [e.g., stop eating once full], decreasing intake of high-fat or spicy food); consider slower dose titration for patients experiencing GI challenges • Pancreatitis has been reported in clinical trials but causality has not been established. Discontinue if pancreatitis is suspected • Evaluate for gallbladder disease if cholelithiasis or cholecystitis is suspected
DPP-4 inhibitors	Intermediate	No	Neutral	Neutral	Neutral (potential risk, saxagliptin)	Neutral	• Renal dose adjustment required (sitagliptin, saxagliptin, alogliptin); can be used in renal impairment • No dose adjustment required for linagliptin	Oral	High	• Pancreatitis has been reported in clinical trials but causality has not been established. Discontinue if pancreatitis is suspected • Joint pain • Bullous pemphigoid (postmarketing): discontinue if suspected
Thiazolidinediones	High	No	Gain	Potential benefit: pioglitazone	Increased risk	Neutral	• No dose adjustment required • Generally not recommended in renal impairment due to potential for fluid retention	Oral	Low	• Congestive HF (pioglitazone, rosiglitazone) • Fluid retention (edema; heart failure) • Benefit in NASH • Risk of bone fractures • Weight gain: consider lower doses to mitigate weight gain and edema
Sulfonylureas (2nd generation)	High	Yes	Gain	Neutral	Neutral	Neutral	• Glyburide: generally not recommended in chronic kidney disease • Glipizide and glimepiride: initiate conservatively to avoid hypoglycemia	Oral	Low	• FDA Special Warning on increased risk of CV mortality based on studies of an older sulfonylurea (tolbutamide); glimepiride shown to be CV safe (see text) • Use with caution in persons at risk for hypoglycemia
Insulin Human	High to very high	Yes	Gain	Neutral	Neutral	Neutral	• Lower insulin doses required with a decrease in eGFR; titrate per clinical response	SQ; inhaled	Low (SQ)	• Injection site reactions • Higher risk of hypoglycemia with human insulin (NPH or premixed formulations) vs. analogs
Insulin Analogs								SQ	High	

*For agent-specific dosing recommendations, please refer to manufacturers' prescribing information. [1]Tsapas A, Avgerinos I, Karagiannis T, et al. Ann Intern Med 2020;173:278–286. [2]Tsapas A, Karagiannis T, Kakotrichi P, et al. Diabetes Obes Metab 2021;23:2116–2124. CVOT, cardiovascular outcomes trial; GIP, gastric inhibitory polypeptide; GLP-1 RA, glucagon-like peptide 1 receptor agonist; NASH, nonalcoholic steatohepatitis; SQ, subcutaneous; T2DM, type 2 diabetes mellitus. Reprinted from Davies MJ, Aroda VR, Collins BS, et al. Diabetes Care 2022;45:2753–2786.