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Oral GLP-1 RA Therapy in Type 2 Diabetes and High Cardiovascular Risk

Announcer:
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Here’s your host, Dr. Brian McDonough.

Dr. McDonough:
This is CME on ReachMD. I'm Dr. Brian McDonough, and joining me to discuss a primary care update in GLP-1 receptor agonist therapy in patients with type 2 diabetes and high cardiovascular risk are Drs. Silvio Inzucchi and Jay Shubrook.

Dr. Inzucchi is a Clinical Chief of the Section of Endocrinology, Medical Director of the Yale Diabetes Center, and Professor of Medicine at Yale University in New Haven, Connecticut. Dr. Jay Shubrook is a board-certified family physician and fellowship-trained diabetologist. He is a full professor in the Primary Care Department at Touro University California College of Osteopathic Medicine.

Dr. Inzucchi, Dr. Shubrook, welcome to you both.

Dr. Inzucchi:
Thank you very much. Good to be here.

Dr. Shubrook:
Glad to be here. Looking forward to this.

Dr. McDonough:
So let's begin with you, Dr. Shubrook. Can you provide an overview of why GLP-1 agonist therapy matters for the primary care physician managing type 2 diabetes in 2026?

Dr. Shubrook:
Thanks, Brian. First of all, it's no surprise to anybody in primary care that our practices are loaded with people with diabetes. I mean, we have many, many patients—more than 10 to sometimes 14 percent of the adult population has diabetes. So we're seeing patients every day, in and out.

And while there are many treatments available, which I think is a good thing, we have lots of options. It's complicated. It's hard to do in a small amount of time, and we have had more success achieving glycemic goals. But when you start looking at comprehensive goals for our patients with diabetes, blood glucose, lipids, and blood pressure, we really are still not meeting the target in more than half these patients.

And so I think there is a need to take a little bit broader of an approach to these patients, and not only just think about glucose, but think more about what's emerging in the cardio-kidney-metabolic syndrome—and I might even argue cardio-kidney-liver-metabolic syndrome

—and start thinking about, how do we comprehensively address these patients?

And we know that type 2 diabetes is a driver and an amplifier for cardiovascular risk. And if we only looked at A1C, we're really not doing the patient justice to make sure that we're addressing the things that lead to death and complications. And so we need to be looking at a much broader comprehensive approach and saying, "How do we address glucose? How do we address excessive adiposity? How do we address glucose variability? How do we help reduce blood pressure, lipids, and other cardiovascular risk, including kidney-related risk?"

And so this is a time for us to not divide the care into the patient, but to really take a more comprehensive approach and say, "Knowing that these things are all linked to each other, how do we find therapies that have benefits beyond just glucose—those that can help these other cardio-kidney-metabolic risk factors—and really simplify and improve the safety of treatment?"

And so I think this is the space where GLP-1 agonists have a real opportunity to broaden the benefits of care, simplify care in many ways, and provide more comprehensive goals.

Dr. McDonough:
Turning to you now, Dr. Inzucchi, can you review the key trials of injectable GLP-1 agonists in patients with type 2 diabetes at high cardiovascular risk?

Dr. Inzucchi:
So, as many of you know, the Food and Drug Administration began to mandate large cardiovascular outcome trials in new diabetes therapies right around 2008 or 2009. So, in contrast to older drugs like metformin and sulfonylureas, we now have a wealth of information as to how these newer glucose-lowering agents impact cardiovascular risk.

In the field of GLP-1 therapy, the initial trial was called LEADER, and this tested the daily GLP-1 agonist known as liraglutide. Some of you may remember that. And it was the first GLP-1 cardiovascular outcome trial to demonstrate a benefit. So here, we're looking at major adverse cardiovascular events, or MACE, between more than 9,000 patients who were randomized to liraglutide versus placebo on top of standard of care. So they could be taking other medications as well.

And at the end of the day, over a period of some four years or so, there was a 13 percent relative risk reduction, hazard ratio 0.87, in favor of liraglutide. It was the first time we've been able to demonstrate that the use of a GLP-1 agonist not only led to better blood glucose control and a loss of body weight and reduction in BMI, but also translated to a cardiovascular benefit.

SUSTAIN-6 was a similarly designed trial using the now-weekly injectable semaglutide, and this study demonstrated an equally robust effect on MACE, again—major adverse cardiovascular events. It was somewhat larger in terms of the point estimate, down to 0.74, so that's a 26 percent risk reduction.

It's hard to compare one study to another. But suffice to say that both daily liraglutide and weekly semaglutide had a beneficial effect on cardiovascular risk.

REWIND was a study that tended to recruit patients that are seen more in primary care. The first two trials were those patients who had overt, established, and somewhat-advanced cardiovascular complications of their type 2 diabetes, whereas REWIND included some of those patients, but also a substantial portion of patients who were so-called primary prevention. In other words, they had risk factors, but actually didn't have established cardiovascular disease. And here, again, there was a MACE effect in favor of the active therapy, which in REWIND was the weekly dulaglutide, with the point estimate of 0.88, so a 12 percent relative risk reduction in favor of the GLP-1 agonist.

There are a few other trials I'd like to just mention. The FLOW trial was a renal outcome trial looking at weekly semaglutide and its impact on the progression of chronic kidney disease. The primary outcome showed a benefit in favor of semaglutide, with a hazard ratio of 0.76, so that's a 24 percent risk reduction. Again, that's a progression of kidney disease. But they also took the opportunity, because many of those patients—even though they were recruited because of their kidney disease—ended up having significant cardiovascular risk factors, so they were at risk for cardiovascular endpoints as well. And the MACE outcome in FLOW calculated to an 18 percent relative risk reduction in favor of semaglutide.

So essentially, across the board, between liraglutide, semaglutide, and dulaglutide, we're seeing cardiovascular benefits.

The last trial I'd like to highlight is known as the SURPASS-CV outcome trial. And in SURPASS, there was a bit of a methodological challenge in that this was the cardiovascular outcome trial of tirzepatide. Tirzepatide is a GLP-1 agonist, but it also activates the GIP receptors, a separate incretin receptor that, when combined with activation of GLP-1, appears to lead to greater hemoglobin A1C and body weight reduction. So because this was a high-risk cohort of patients in SURPASS-CVOT, as it was called, the investigators

decided to compare tirzepatide to dulaglutide, so there's an active comparator.

And the main outcome was essentially similar between those two groups—those randomized to dulaglutide versus tirzepatide—with the hazard ratios being 0.92. But there was no statistical difference between the two groups. So with the tirzepatide, patients had numerically less events, but again, not statistically significant.

Dr. McDonough:
Thanks for a great summary, Dr. Inzucchi. And with that context in mind, Dr. Shubrook, can you describe the need before the SOUL trial was conducted for oral GLP-1 agonist therapy in primary care patients with type 2 diabetes and high cardiovascular risk?

Dr. Shubrook:
I just want to highlight something that Dr. Inzucchi said, that, when the first couple trials came out, looking at cardiovascular risks with GLP-1 receptor agonists, we didn't really know that there was going to be a benefit. And I remember seeing the early leaders say, "Well, I don't know if that's real or if that's just one agent." I mean, we're seeing pretty consistently that there is benefit—not only safety, but benefit—in the cardiovascular space with GLP-1 agonists. And so, for me, that was a game changer in the way we approached it.

And all of these agents early on were injections. I'm someone that does a lot of injection therapy for our patients, including insulin, so the conversation about injections wasn't very complicated. And certainly, as we went from once daily to once weekly injections, it was a pretty easy thing for patients to see, particularly if there were additional benefits. But that's not for everyone, right? We all have some patients that are just a hard no when it comes to injections, and some clinicians, quite honestly, might be not comfortable with injections. And so it may show that patients might also be less likely to have injection therapy.

So there was always a need: could we have agents that were not injectable that could give you similar benefits? And so certainly, we saw the emergence of oral GLP-1 agonists, and that's really exciting.

I think one of them we want to highlight is oral semaglutide. It was the first oral agent to come out. And in its pivotal cardiovascular safety trial, the PIONEER 6, it was looking at adults age 50 and above who had cardiovascular disease or those 60 and above that had cardiovascular risk, and randomized them to oral semaglutide or placebo, looking at events. This is an FDA-mandated trial saying, "Does this give benefit not only for glucose, but also not creating excessive cardiovascular risk?"

And in that trial, the primary outcome was that MACE—that you've already heard about—and the hazard ratio was 0.79, which met the non-inferiority, meaning that there was no cardiovascular risk for oral semaglutide. But it did not quite meet the superiority, showing that there was cardiovascular benefit.

Now, at a very first level, I want to know all medications are safe, and they're not going to cause undue harm to my patients. But since we had these very positive results for injectable therapies, I've really wanted to have the same option for oral therapies. Prior to that, I certainly knew that with oral, GLP-1 agonist therapy can work. It can certainly be very effective for lowering hemoglobin A1C in patients in this trial. These were our secondary outcomes, not primary. So you saw a significant reduction in the hemoglobin A1C compared to placebo. You saw a significant reduction in weight. But the question is, can we get that cardiovascular benefit?

And so there was that unmet need to say, "If we're going to be using oral agents, can we actually start to see benefit above and beyond glucose, so that these agents are really meeting the needs of these patients in CKM?"

Dr. McDonough:
And Dr. Inzucchi, what is the design and key findings of the SOUL trial?

Dr. Inzucchi:
Well, as Jay just told us, the PIONEER trial was too small a study to say anything definitive about superiority of this oral formulation of semaglutide. So we designed the SOUL trial specifically to answer that question. In other words, if we recruited more patients, could we demonstrate actual superiority of oral semaglutide on MACE versus placebo?

This is essentially a classical CV outcome trial. Patients were recruited to be at high cardiovascular risk, so we took patients who had overt cardiovascular disease. Plus, a proportion of our patients had just chronic kidney disease, because we know that patients with CKD are themselves at increased cardiovascular risk.

They were randomized to oral semaglutide versus placebo, and like all CVOTs recently, the primary outcome was MACE: that composite of cardiovascular mortality, non-fatal myocardial infarction, and non-fatal stroke. We also had a key secondary outcome of major adverse limb events. Some call this MALE, M-A-L-E, to describe amputations, revascularizations, etc.

But peripheral arterial disease is very common in patients with type 2 diabetes, and there's been some preliminary evidence suggesting that GLP-1 agonists may actually help claudication or vascular outcomes in patients with advanced PAD. So the primary outcome—

again, MACE—was favorable for oral semaglutide.

And because we recruited more than 9,000 patients, we achieved a statistically significant effect with a 14 percent relative risk reduction of oral semaglutide versus placebo, the hazard ratio being 0.86. And this was over a period of, on average, about three to four years of therapy. For that MALE outcome—the limb event outcome—the hazard ratio appeared even more impressive, with a value of 0.71, so a 29 percent risk reduction, in the PAD outcome.

And importantly—this has been an interest of mine—is what is the potential for combination therapy between an SGLT2 and a GLP-1 agonist? As all of you know, the GLP-1 receptor agonist field has exploded in the past five or six years. But the SGLT2s were actually the first drug category to be definitively shown to reduce major adverse cardiovascular events. And many of us have been using the SGLT2 inhibitors for more than 10 years now based on those data.

So the key question is, what if you have a patient, and you're treating them with an SGLT2? Can you add a GLP-1 and expect even greater benefit on some of those cardiovascular outcomes? Or vice versa: if you have somebody on a GLP-1 and then then they add an SGLT2? There's been a lot of interest in the clinical trial community in trying to dissect patients in the more recent clinical trials, where there's been prevalent use of either SGLT2s in a GLP-1 trial or GLP-1 at baseline in an SGLT2 trial.

In SOUL, we're obviously testing the GLP-1 oral semaglutide, but about a quarter of our patients came into the trial already on one of the two or three SGLT2 inhibitors that are in widespread use in the countries where the study was conducted. At the end of the study, we had more than 40 percent of our patients on an SGLT2 inhibitor.

I actually doubt there'll ever be a combination trial between an SGLT2 and a GLP-1 compared to monotherapy with each of those drug categories. It's going to be too complicated a study, too long, too expensive. I really don't think we'll ever see one. What we found in SOUL, in terms of 25 percent at baseline and 40 percent or more at the end of the trial, may represent the largest experience we'll ever have with this combination approach. And the bottom line is that, whether patients came into the study on an SGLT2 inhibitor or not, the treatment effect of the GLP-1 agonist oral semaglutide was indistinguishable.

What that means is that whether you're not taking or taking an SGLT2 inhibitor doesn't modulate or modify the benefits of the GLP-1 agonist. When statisticians look at these data, their terminology is that there must be an additive effect. Now, I would caution you, it’s not a synergistic effect, as some have proposed—that two plus two equals five, not just four—but at least there's an additive benefit on the MACE outcome.

And finally, when we look at the safety profile, like all of these GLP-1 agonist trials, there tends to be more GI adverse events—particularly nausea, some vomiting, constipation, and diarrhea—that you see in the active therapy group. But, for the most part, particularly with hypoglycemia, there doesn't seem to be any increase in the risk. There are some concerns regarding some more rare potential side effects, but these tend not to be seen in these clinical trials, which focus on some 3,000 to 9,000 patients. They’re too rare of events to be distinguishable in these clinical trials.

Dr. McDonough:
To build on that, Dr. Inzucchi, how do the SOUL trial results compare with results from trials with injectable GLP-1 receptor agonist therapies?

Dr. Inzucchi:
Well, we actually had the opportunity—with SOUL being the most recent of the GLP-1 receptor CV outcome trials—as we were putting together the SOUL paper, to actually conduct the latest and the largest meta-analysis of all the GLP-1 CV outcome trials. And what we found was, when we compiled the data going back to LEADER and ending in SOUL, that the effect on three-point MACE—again, CV mortality, MI, and stroke—was a 14 percent relative risk reduction. Again, that’s a hazard ratio of 0.86. Interestingly, that's exactly the results we had from SOUL by itself: 0.86 with a 14 percent relative risk reduction. So the conclusion is that SOUL shows that oral semaglutide is essentially representative of the entire class.

Dr. McDonough:
For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Brian McDonough, and today I'm speaking with Drs. Silvio Inzucchi and Jay Shubrook about oral GLP-1 receptor agonist therapy in patients with type 2 diabetes and high cardiovascular risk.

Shifting gears to another important topic, Dr. Shubrook, what do current guidelines recommend for GLP-1 receptor agonist use in patients with type 2 diabetes and cardiovascular risk?

Dr. Shubrook:
So I think we've really seen some nice congruence of the guidelines across all specialties—diabetes, cardiology, and kidney—all really

kind of saying the same thing. In primary care, most people probably follow the ADA guidelines. And the ADA guidelines are very clear that, when you're treating someone with type 2 diabetes, the first thing you want to assess is, do they have unique risks?

If the person—regardless of if they're newly diagnosed or established—has atherosclerotic cardiovascular disease or high risk factors of those, if they have CKD, or if they have heart failure, these are all patients that you should be considering targeted therapy for that have extra glycemic benefits in addition to the glycemic benefit.

For example, if I have someone with atherosclerotic cardiovascular disease, regardless of their A1C, I should be making room for therapies that are going to give them cardiovascular benefit, such as a GLP-1 agonist. If they have chronic kidney disease, I should be making sure that part of their therapy is an SGLT2 inhibitor or a GLP-1 receptor agonist. If they have heart failure, SGLT2 is kind of the main class, but we have emerging evidence there will still be some benefit maybe from GLP-1 agonists. So you're going to see that these two therapies actually fall across all of the compelling indications for people with type 2 diabetes, being atherosclerotic cardiovascular risk factors, heart failure, or CKD.

Now, the reason why that's important is these agents can be expensive, and if you're writing them in primary care, you're going to want to make sure that you're doing guideline-directed therapy. And you can use those guidelines to justify the need for those, especially when there's an agonist with specific indications for the reason you're writing it.

I do think there's very good support, and, as you've heard, very good evidence, not only with recent agents, but across the spectrum of these agents having extra glycemic benefit, and we need to include them and make room for them, which might mean removing agents that have only glucose-related benefit so that we can get the max benefit for our patients.

When I'm talking to patients, I tell them, "I'm not just treating your diabetes now. I'm treating your diabetes and potentially reducing cardiovascular risk," or, "I'm treating your diabetes and helping your kidneys," or, "I'm reducing the risk of peripheral arterial disease or helping the liver." I think this is really nice, because the patients are thinking, "Oh my goodness, I'm not getting one problem, one med, or one problem, three meds—I've got one med that might help three problems." And I think that's something that could really help with patient engagement and, quite honestly, in the primary care space, help with simplicity of treatment rather than polypharmacy.

Dr. McDonough:
And Dr. Inzucchi, when it comes to oral semaglutide specifically, how should a provider prescribe and counsel patients about it?

Dr. Inzucchi:
Well, it's not that dissimilar from the injectable varieties of these GLP-1s, because the initial dose has to be low or else you will have more of the GI side effects. And it needs to be built up slowly, typically with titrations every month, until you get to a desired dose or the maximal dose.

Now, with oral semaglutide, there's a unique formulation. These are peptides, and peptides and gastric acid don't do well together. So there had to be a trick to get the GLP-1 agonist through the gastric mucosa. And the technology that was developed was a molecule called SNAC, S-N-A-C, which essentially facilitates the absorption of semaglutide in this oral semaglutide formulation. There is a little bit of a specific technique, in that the medication is taken in the morning with up to four ounces of water, and nothing should be eaten for at least 30 minutes after that administration. That allows the medication to be absorbed.

The oral and injectable formulations of semaglutide are very, very similar. There's a little bit more variability when you're using the oral form than the injectable, and I think that's understandable. But you can minimize that variability through this specific procedure of less than four ounces of water, nothing to eat or drink for 30 minutes after.

The GLP-1 agonists have GI side effects, but they're accentuated if the titration is too rapid and if you start with a larger than the initially recommended dose. For oral semaglutide, there are now two formulations. The original started with three milligrams, increasing to seven and then 14 milligrams monthly. The newer formulation appears to be more potent in terms of the absorption capacity, so that with the newer versions, we start at 1.5 milligrams, titrate to four, and then finally to nine milligrams. Those titrations are done on a monthly basis.

In terms of coaching patients, I tell my patients prescribed any type of GLP-1 agonist why we're starting slow, and to eat slowly. There's an effect on gastric emptying. And for patients, it's important for them to understand that when they feel full, that's an important signal from the stomach, and that should lead to a cessation of eating—because if not, then I think there can be certainly more nausea and maybe even some vomiting. So that's very, very key. We have them try to avoid fatty or greasy foods, and also to concentrate on the protein intake in order to maintain muscle mass.

There are some other rare concerns about the GLP-1 agonists. In animal models, they've stimulated a specific type of thyroid cancer, which is known as medullary cancer and is very rare in humans. But we do avoid them, obviously, in those rare patients with medullary

cancer and patients who are members of kindreds with multiple endocrine neoplasia syndromes, or MEN, syndromes.

And there still is this package label contraindication for patients who've had pancreatitis. As you look at the data from the CV outcome trials, there tends to be no imbalance in terms of pancreatitis. Patients with diabetes are predisposed to pancreatitis. What the GLP-1 agonists probably do is increase gallbladder stones and therefore the need for cholecystectomies, and I suspect that some of the early reports may have been related to gallstone pancreatitis.

But there really isn't any convincing evidence, at least in my mind, that the drugs have a toxic effect on the pancreas, yet the label still counsels us not to use them in patients with pancreatitis. But with any medication, proper patient selection and counseling are going to be very important.

Dr. McDonough:
This is a great conversation, because many primary care doctors are just starting to use these medicines in the oral form. And so, with the 1.5 dose, I would assume for the first month that almost feels like almost a homeopathic dose, getting people kind of used to it before you escalate it.

Dr. Inzucchi:
Yeah, it is a starter dose, and usually it's something just to get accustomed to it. And the more efficacious doses are certainly going to be four milligrams and nine milligrams for that new version.

Dr. McDonough:
This next question's for both of you. As clinicians managing these patients, how do you choose between injectable and oral GLP-1 receptor agonist options, since you have those options?

Dr. Shubrook:
So this is a really important question. First of all, it's wonderful that we have these choices. So these are medicines that patients will probably be taking for a very long time. This is chronic disease management, and so shared decision-making is really important. So look at what they're currently doing, look at what their goals are, and then, I think, give them the choice, right?

Especially if you have data to support their use. And then, many times, people will say, "I may want an injection because I'm more familiar with it," or, "I may want the oral because I have a lot of tablets." There are some people that just say, "You know, if I can take a tablet and I can do this regimen, I would much rather do that."

Dr. Shubrook:
What do you think, Dr. Inzucchi?

Dr. Inzucchi:
Well, I don't have much to add. I think it's good to have choices. I think patients kind of gravitate either to injectables or oral agents. I think it's also appropriate to start with one and see how they do, and switch to another if they're not happy with a certain formulation.

I do think that when the orals have been compared to the injectables, you do tend to get more A1C reduction and more body weight loss with the injectables. Now, whether that's because the injectables are more reliable, that there's less variability, is not quite clear. But I think the point from the cardiovascular perspective is that, when you look across the CV outcome trials, the effect of semaglutide delivered orally in SOUL was right on the line in terms of the relative risk reduction that you can expect from any GLP-1 agonist.

Dr. McDonough:
And another question for both of you: should a provider combine a GLP-1 receptor agonist with an SGLT2 inhibitor, and if so, when?

Dr. Inzucchi:
Well, as Dr. Shubrook mentioned before, the cost is a major concern, right? These drugs are, for the most part, still, not generically available, although I understand that one of the SGLT2s is or will soon be generically available: dapagliflozin. But most of them are not. So we're talking about substantial cost, particularly if patients are not getting insurance coverage and have to pay out of pocket. So that needs to be considered.

Having said that, if costs were not an issue, I personally think that we're evolving to a point in diabetes management with so much cardiovascular disease, so much CKD, that we probably should be starting these medications from the get-go in combination. They have different mechanisms of action. They have unique benefits. As Dr. Shubrook mentioned, the heart failure benefits are extreme with the SGLT2 inhibitors, and we're just beginning to learn about the heart failure benefits from the GLP-1 agonists. There may be an additive effect, as was suggested in the SGLT2 inhibitor patients that were recruited into SOUL, at least from the MACE standpoint.

I think the verdict is still out as to whether there is an additive effect for the kidney endpoints. We're not quite sure of that. There are different opinions on both sides of the fence regarding the renal outcomes. But certainly, from an A1C standpoint, from a weight standpoint, these drugs are going to have additive effects.

So while that may not be in the guidelines, many of us are gravitating to that point, that patients should just be initiated on both of these. Once the SGLT2 inhibitors are widely available generically, I think that will be less of a concern in terms of cost.

Dr. Shubrook:
Brian, I'm going to add something. I wanted to highlight something that Dr. Inzucchi said, that because we have so many different agents, do not feel like you need to throw out the class if you have side effects with one, because the side effects are rather idiopathic. Use the one that you want to use for the indication, but if you have side effects and you can't work on a titration, please consider another one, because the benefits have been shown when you do these meta-analyses that we'd rather have them on one than on none if they have the compelling indications.

Dr. McDonough:
Drs. Inzucchi and Shubrook, thank you for a great discussion. Before we wrap up, would you each provide two or three key take-home messages for our audience?

Dr. Shubrook:
Yeah, I think it is a really great opportunity, now that we have agents that have extra glycemic benefits, to think of our patients more globally, and not just think of diabetes. Let's think of CKM or CKLM, and let's use agents that will give benefit. And you heard today that maybe earlier intervention with these agents not only is effective, but can really potentially reduce the risk and cost downstream.

And so there really will be an opportunity for us to intensify early therapy with targeted agents that could give this long-term benefit. And since more than 50 percent of our patients are not achieving those global goals, we have plenty of room to improve our treatments. And as you think of these agents, the GLP-1 agonists, please know that they are strong, and they're safe.

Dr. McDonough:
Dr. Inzucchi.

Dr. Inzucchi:
Yeah, just a couple of extra points. Obviously, obesity is at the heart of type 2 diabetes in many circumstances. And when you address obesity, very often, glycemic control improves, and that's what we're seeing with the GLP-1 agonist. But in addition, there's many other complications of obesity that we haven't talked about today. We've talked about adverse cardiovascular events, we've talked about CKD progression. But patients who are obese, particularly those with class II and class III obesity, have a number of other complications. We haven't addressed fatty liver disease, osteoarthritis, or obstructive sleep apnea. As data emerges, it appears that the GLP-1 agonists appear to have substantial benefits in some of these other complications as well.

And the final point is that we are in a brave new world of diabetes management. It's so much more gratifying to treat patients with diabetes and obesity nowadays, because we finally have the tools to not only address glycemia and obesity, but also the end results of those conditions, which is certainly on the cardiovascular system.

Dr. McDonough:
That's a great way to round out our discussion. I want to thank my guests, Drs. Silvio Inzucchi and Jay Shubrook, for helping us better understand how GLP-1 receptor agonist therapy can help to improve clinical outcomes in appropriate patients with type 2 diabetes and high cardiovascular risk.

Dr. Inzucchi, Dr. Shubrook, it was great speaking with you today.

Dr. Inzucchi:
Thank you. I enjoyed it.

Dr. Shubrook:
Thank you very much.

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