Transcript Details
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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Addressing Cardiovascular Risk in Prediabetes: Why Earlier Action Matters

Announcer:
This is *Diabetes Discourse* on ReachMD. On this episode, Dr. John Ostrominski will be recapping his presentation at the 2026 European Association for the Study of Diabetes Annual Meeting, which posed the following question: Should treatment options in prediabetes also mitigate cardiovascular risks? Dr. Ostrominski is a preventive cardiologist and obesity medicine specialist at Brigham and Women's Hospital and Harvard Medical School. Let's hear from him now.

Dr. Ostrominski:
Cardiovascular risk in someone with prediabetes is a central focus, I think, of any approach to clinical care. And even taking a step back, this also fits with our paradigm in cardiovascular prevention, which is to better understand someone's underlying risk as comprehensively as possible.

So for instance, if I'm seeing someone in clinic for the first time, I'll always frame it as we are first going to do some information-gathering to better understand your risk. We will leverage that information to then dictate the intensity of our interventions and the types of interventions. A classic example would be if someone, for instance, has prediabetes and then they also have an indication for chronic kidney disease screening. If we do that screening and we find evidence of chronic kidney disease, we will then more intensively treat that person, targeting ideally both the kidney disease and the prediabetes. And so often, phenotyping of cardiovascular, kidney, and metabolic risk using blood tests, urine tests, and other simple things that we do in clinical practice, such as waist circumference measurements, weight measurements, and blood pressure measurements, are tools that we have readily accessible to us to better understand someone's global profile of risk.

And then the ideal clinical approach at the individual level would be to integrate all of that information to then establish the most tailored and individualized approach to prevention. And so right now, there isn't yet a trial that's shown that a specific intervention exclusively in people with prediabetes reduces cardiovascular risk. Because of that limitation, a lot of our current efforts are just practically focused around identifying risk, identifying other diagnoses that provide a pathway for intervention, and then ideally taking into account all those individual factors and treating someone more or less intensively on the basis of those risk factors.

Prediabetes should not be addressed passively. I think we've historically thought about it as a gateway to diabetes and that risk of cardiovascular disease emerges thereafter. But actually, the majority of cardiovascular events that occur in people with prediabetes occur prior to the onset of diabetes. And so the first core theme is that risk reduction interventions should not be deferred until diabetes emerges. There are targetable and modifiable elements and domains of risk that could reduce someone's longitudinal risk of adverse outcomes.

But I also think that we can take a step back and think about what it means to be a healthcare professional. Common sense would tell us that any disease is bad; risk is bad. We don't need a trial to say that prediabetes is bad, and therefore, we don't need a trial to say that remission of prediabetes is a good thing. Remission of any disease state is one of the key and ultimate patient-centered goals of any healthcare practice, and that, I would argue, includes prediabetes. And so in my clinical practice, what I'm increasingly trying to do is not address prediabetes passively but use it as an invitation for not only comprehensive risk stratification but intensive management. And that intensive management, I would argue, should target remission of prediabetes. And notably in clinical trials, remission of prediabetes has been shown to be associated with a nearly 50 percent reduction in future risk of cardiovascular disease.

Announcer:
That was Dr. John Ostrominski discussing whether treatment interventions in prediabetes should also mitigate cardiovascular risks. To

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