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Treating the Individual: Personalized Care Strategies for Patients With Type 2 Diabetes & ASCVD

ReachMD Announcer:

Welcome to *Heart Matters* on ReachMD. This episode is sponsored by Novo Nordisk. Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:

With atherosclerotic cardiovascular disease, or ASCVD, being the number one cause of death and disability for patients with type 2 diabetes,¹ it's time we take a closer look at how it affects our patients, and perhaps even more importantly, how we can invite them to join the fight. So what do the latest guidelines tell us? And how can taking an individualized approach to treatment help? We'll find out on today's program.

This is ReachMD, and I'm your host, Dr. Jennifer Caudle. And joining me to share treatment strategies for patients with ASCVD and type 2 diabetes is Dr. Joshua Stolker, an interventional cardiologist at Mercy Heart and Vascular, both in Washington, and Saint Louis, Missouri. Dr. Stolker, thanks so much for joining us.

Dr. Stolker:

Sure. Thanks for having me.

Dr. Caudle:

To start us off, Dr. Stolker, would you give us a high-level overview of the risk of ASCVD in patients with type 2 diabetes?

Dr. Stolker:

Oh, sure. So as you mentioned earlier, atherosclerotic cardiovascular disease is the number one cause of death and disability in patients with type 2 diabetes, and it's been shown to occur 14.6 years earlier than in patients without diabetes.¹

And in addition, life expectancy for a 50-year-old is reduced by approximately 7 years for patients with type 2 diabetes,² and in someone with diabetes who's already had a heart attack, or a stroke, or both of these by the time they're 50 years old, life expectancy can be reduced by as much as 15 to 20 years, when compared with somebody without these comorbidities.²

And furthermore, an adult with type 2 diabetes is hospitalized for stroke every 2 minutes in the United States.³ And unfortunately, that's how common these complications have become in type 2 diabetes.

Dr. Caudle:

And keeping these data in mind, what challenges do patients and clinicians face when managing the complexities of type 2 diabetes and accompanying ASCVD?

Dr. Stolker:

Well, that's a good question. Clinicians may prescribe several different medicines to achieve optimal levels of glycemic control, along with other classes of medicines for managing a patient's cardiovascular risk. The problem is that patient compliance may decrease as the number of medications increases.¹

And in addition, despite the high prevalence of type 2 diabetes in our patients who already have atherosclerotic cardiovascular disease, there are fewer diabetes specialists to manage these patients, with recent estimates showing that there are far more cardiologists and primary care physicians than there are endocrinologists or diabetologists.⁴ So much of the responsibility to care for these patients is placed on primary care^{4,5} and, from what my colleagues and I have experienced, it's placed on cardiovascular clinicians as well.

And with over 10 medication classes and more than 20 medications available to treat type 2 diabetes, some clinicians may find it challenging to keep up with the latest treatments and the latest guidelines, and this can result in therapeutic inertia, a lack of timely treatment adjustments – and failure to get the patient's A1C under control can leave them at risk of many complications, which can include events like a heart attack or a stroke.⁵

So in my role as an interventional cardiologist, I focus on making sure patients are on medicines that reduce their cardiovascular risk. And traditionally, this has mainly involved treating lipids, lowering blood pressure, and managing lifestyle choices such as smoking, diet, exercise—all of which is done regardless of diabetes status. But specifically for patients with type 2 diabetes and established cardiovascular disease, in the last 5 to 7 years, there have been more and more cardiovascular outcomes trials with type 2 diabetes medications that have shown and demonstrated cardiovascular risk reduction in patients with type 2 diabetes and established cardiovascular disease.¹

Dr. Caudle:

That's great, Dr. Stolker. Now if we stay with that theme, and with so many variables here, how can clinicians better manage their patients with type 2 diabetes?

Dr. Stolker:

Well, the latest outcomes-based guidelines suggest that treatment in patients with type 2 diabetes shouldn't focus on glucose-lowering agents or hemoglobin A1C targets alone, but they really should also address cardiovascular risk when appropriate because, in patients with established cardiovascular disease or those at high risk of cardiovascular disease, this entails a much more individualized approach to care.⁶⁻⁸

For example, recommendations from the American Heart Association and the American College of Cardiology support the use of GLP-1 receptor agonists or SGLT-2 inhibitors with proven cardiovascular benefit, meaning a label indication from the FDA for proven cardiovascular disease benefit. And that's because many of these drugs have demonstrated cardiovascular risk reduction for patients with type 2 diabetes who also have established cardiovascular disease or are at high risk of developing cardiovascular disease.^{6,8}

And, I should also mention that the 2022 ADA guidelines recommend a GLP-1 receptor agonist and/or an SGLT-2 inhibitor with a label indication for proven cardiovascular benefit, as part of the glucose-lowering regimen and the comprehensive cardiovascular risk reduction strategy in these patients with type 2 diabetes who also have established cardiovascular disease.⁷

Dr. Caudle:

For those just tuning in, you're listening to Heart Matters on ReachMD. I'm your host, Dr. Jennifer Caudle, and I'm speaking with Dr. Joshua Stolker about how we can take an individualized approach to caring for patients with type 2 diabetes.

Dr. Caudle:

Now, Dr. Stolker, let's dive a bit deeper into the concept of patient-centered care. What types of personalized strategies can we implement to help care for our patients with type 2 diabetes and established CVD?

Dr. Stolker:

Sure, so in addition to the potential comorbidities I just mentioned, many criteria come into play when choosing therapy. For example, we need to consider a patient's ability to access these medicines. We have to think about preference, we have to think about how these medicines are administered, as in taking daily medicines versus once-a-week injection options. And of course, individualized A1C targets and the potential impact on weight.⁵

You know, in my practice, I think about all these factors to personalize a treatment plan for each one of my patients. It's really my judgment call, sometimes with the help of a patient's endocrinologist and their primary care physician, as to which drug or which regimen is most likely to improve my patient's overall cardiovascular and diabetic outcomes.

So after discussing these treatment goals with the patient, we can work together to implement a plan that seems best for that particular patient, which helps provide him or her with this sense of empowerment in being more involved in the decisions about improving their own care. Then, it's the clinician's job to regularly monitor the treatment, make therapeutic changes as necessary, adjust dosing, and so forth.⁵

It's important to keep the goals of care in mind when selecting treatment for diabetes patients with different comorbidities, and these are to help control their blood sugar and potentially lower their cardiovascular risk if they have cardiovascular disease.¹

In my practice, I definitely notice a level of satisfaction that comes when the patients are involved in their own treatment plans. These are the reasons why I'm so passionate about using these therapies to help patients who have type 2 diabetes and established

atherosclerotic cardiovascular disease.

Dr. Caudle:

Thanks for sharing that, Dr. Stolker. And before we close, do you have any takeaways for our audience?

Dr. Stolker:

Yes. I really think it's our duty to incorporate outcomes-based guidelines into practice, and to implement medications and styles of therapy that can improve outcomes for each of our individual patients.⁵ To me, an individualized approach to patient care can help us to improve outcomes for our patients, while simultaneously allowing patients to be more involved and more interested in improving their own care. Because ultimately, our goals are similar to the patient's, right, which is to help control their blood sugar when they have type 2 diabetes and, in some cases to help lower their cardiovascular risk.¹ And that's really at the heart of it all.

Dr. Caudle:

Well with those best practices in mind, I'd like to thank my guest, Dr. Joshua Stolker, for joining me to share his perspectives on this important topic. Dr. Stolker, it was great having you on the program.

Dr. Stolker:

Thanks, it was a pleasure to be here.

ReachMD Announcer:

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