

Prise en Charge du Diabète

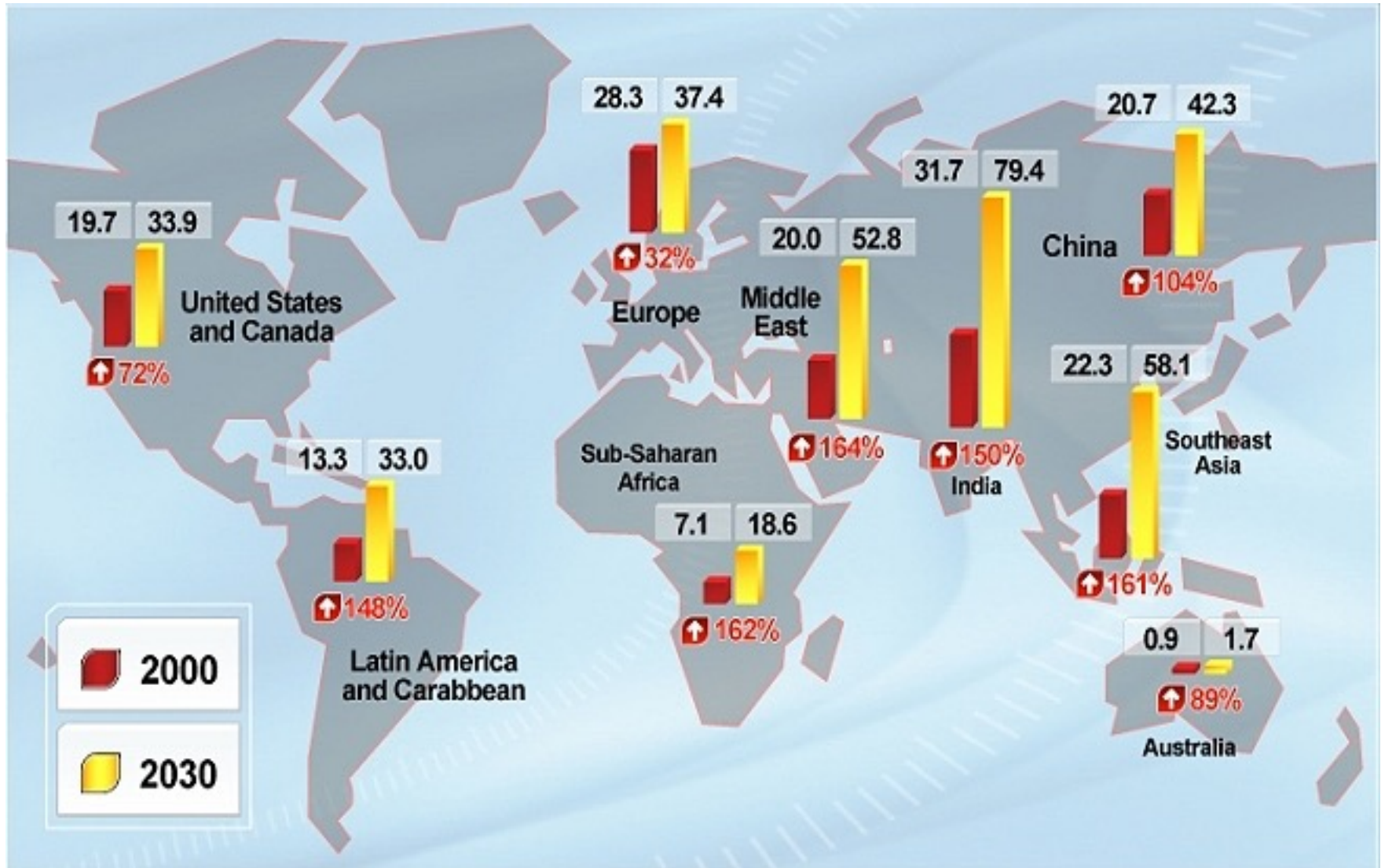
Recommandations Société Européenne de Cardiologie (ESC) 2023

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Facteurs de Risque Cardio-Vasculaires : Diabète

Prévalence en million de diabétiques - Projection pour 2030



Facteurs de Risque Cardio-Vasculaires : Diabète

Mortalité liée au diabète en France

- Part des décès dans la mortalité générale : 6,1 %
- Par rapport à population non-diabétique :
Ratio de mortalité : 1,45
- Causes :
 - * **Appareil circulatoire : 60 %**
 - * Diabète : 34 %
 - * Tumeurs : 32 %
 - * Insuffisance rénale : 8 %

Facteurs de Risque Cardio-Vasculaires : Diabète

Diabète et complications Cardio-Vasculaires

Par rapport à population non diabétique,
le risque d'hospitalisation de la population des patients
diabétiques est :

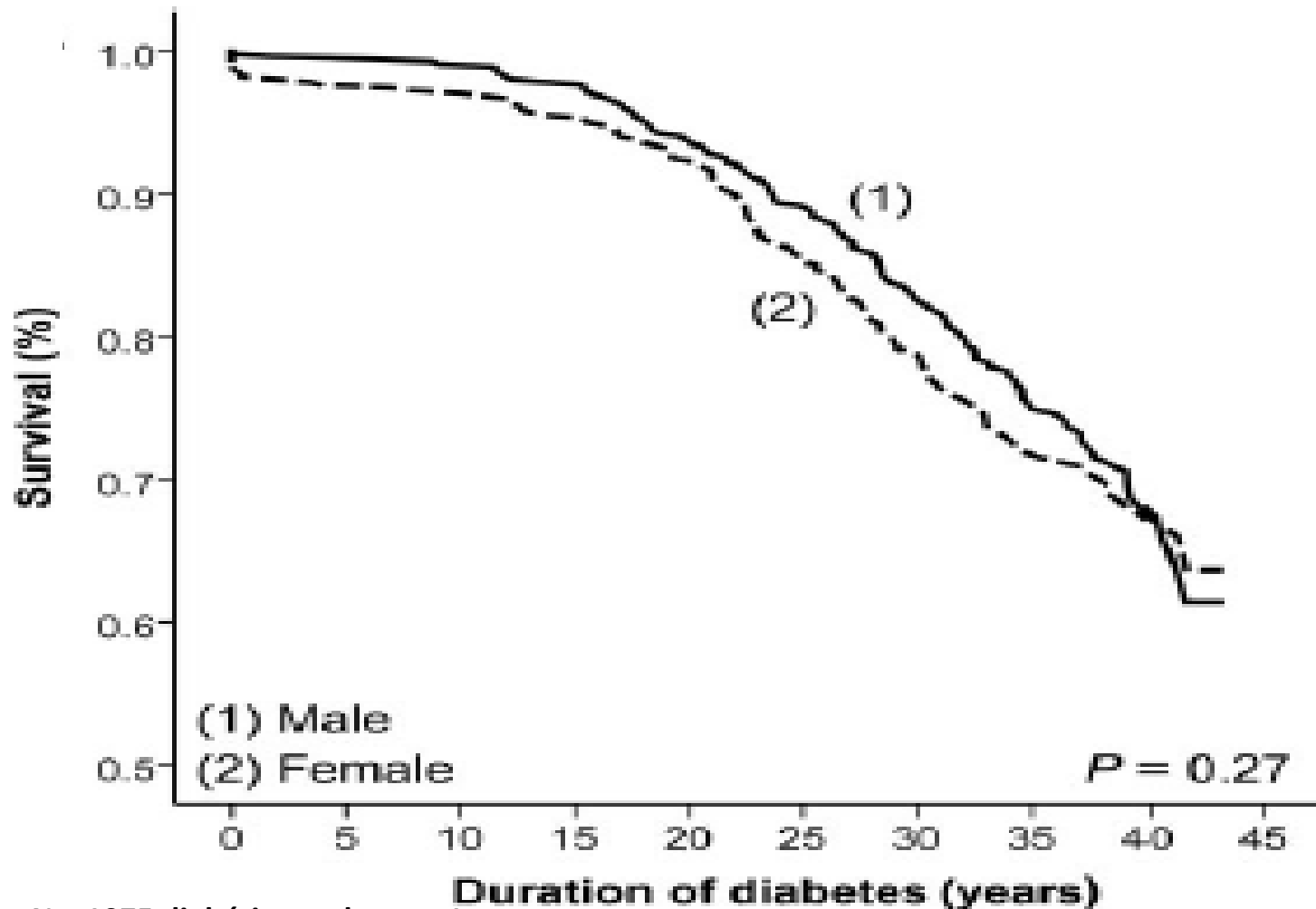
x 1,6 pour l'AVC

x 2,2 pour l'Infarctus du Myocarde

x 7 pour l'amputation d'un membre inférieur

Facteurs de Risque Cardio-Vasculaires : Diabète

Diabète de type 1 et mortalité

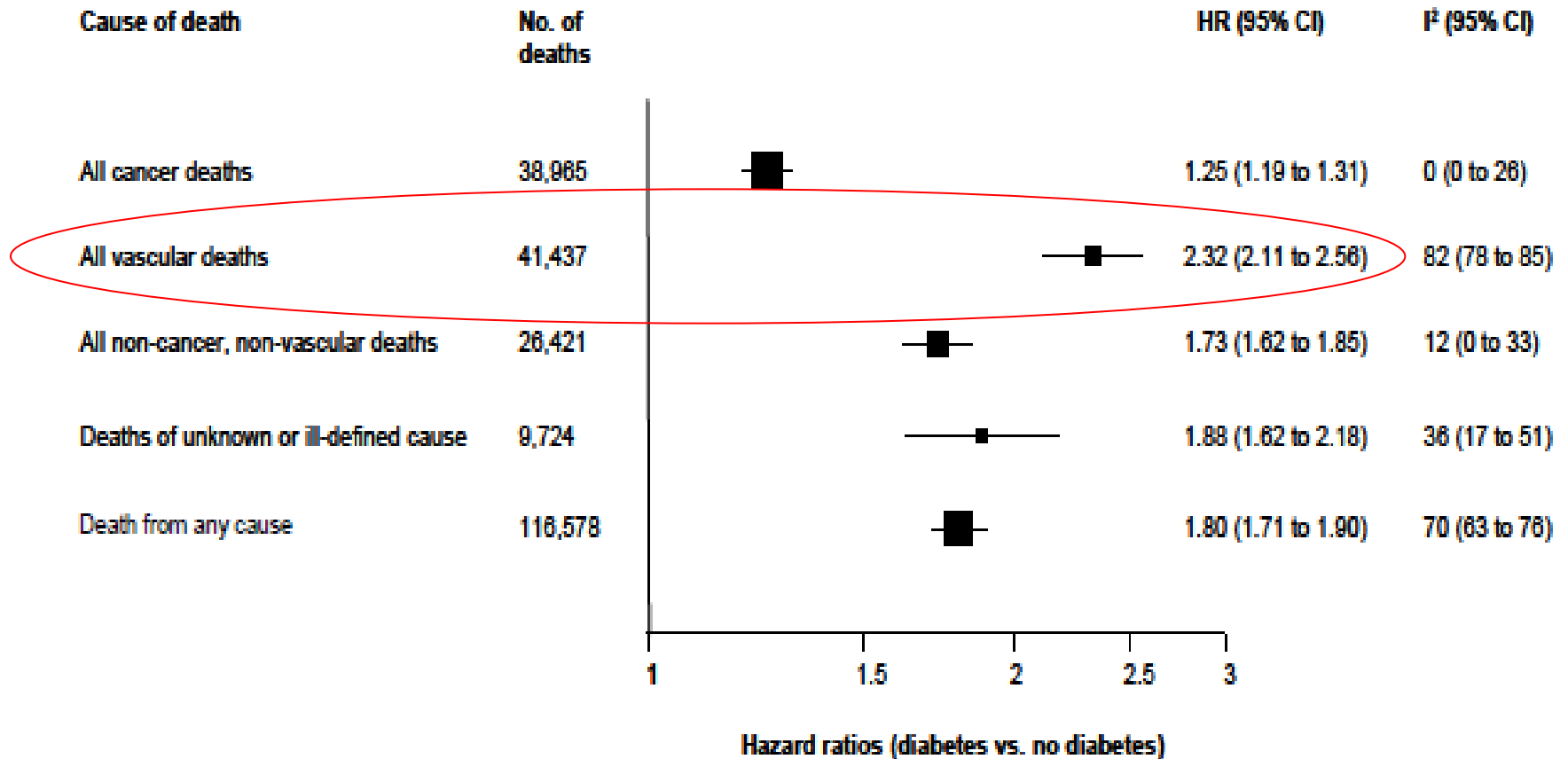


Méthodologie : N = 1075 diabétiques de type 1

D'après SECREST AM, Diabetes Care, 2010.

Facteurs de Risque Cardio-Vasculaires : Diabète

Diabète de type 2 et mortalité Cardio-Vasculaire



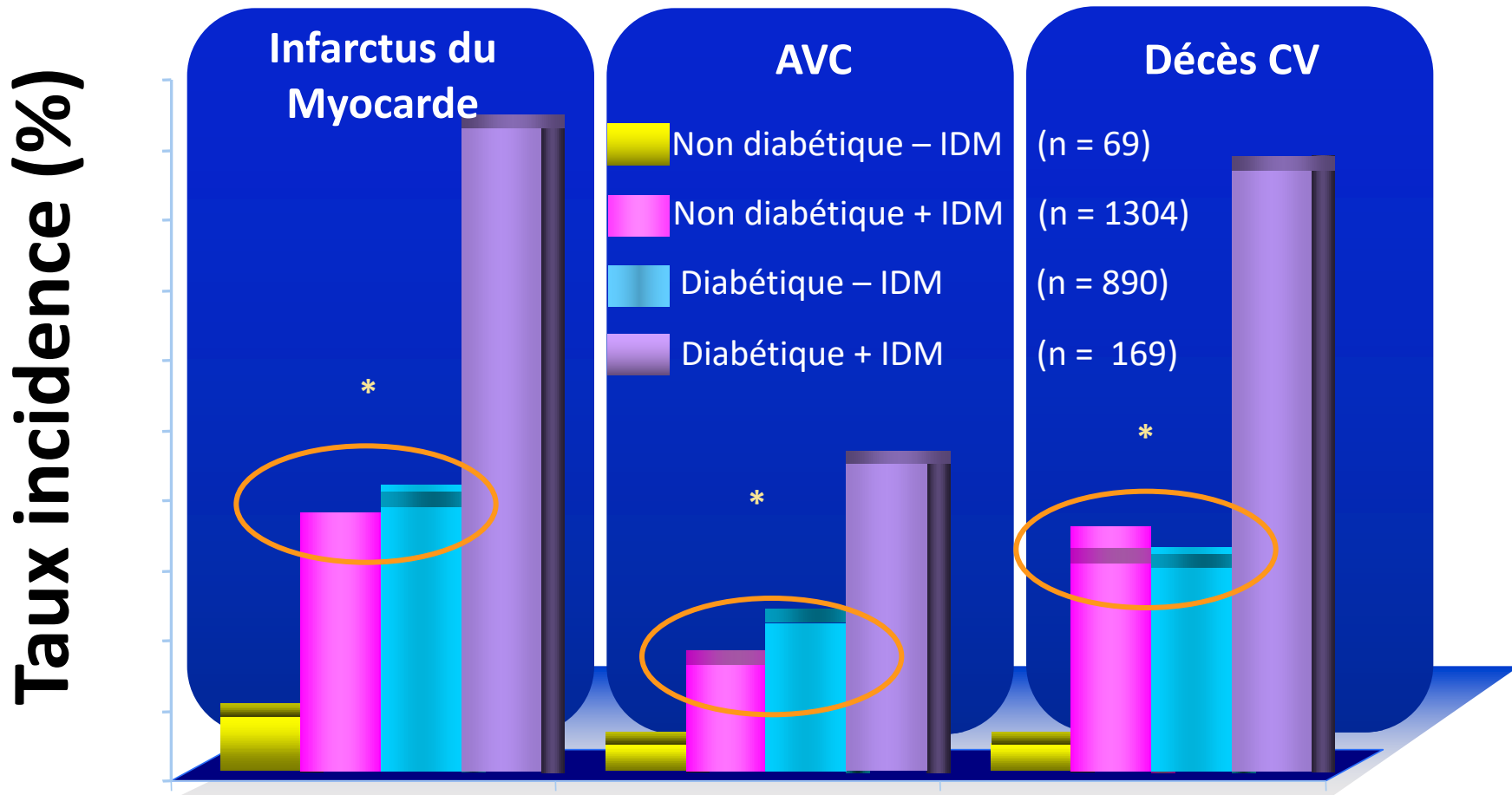
Méthodologie : 97 études cas-contrôle prospectives regroupant 40116 diabétiques et 674945 non-diabétiques

Ajustement : âge, sexe, tabagisme et IMC

D'après Emerging Risk Factors Collaboration, NEJM 2011.

Facteurs de Risque Cardio-Vasculaires : Diabète

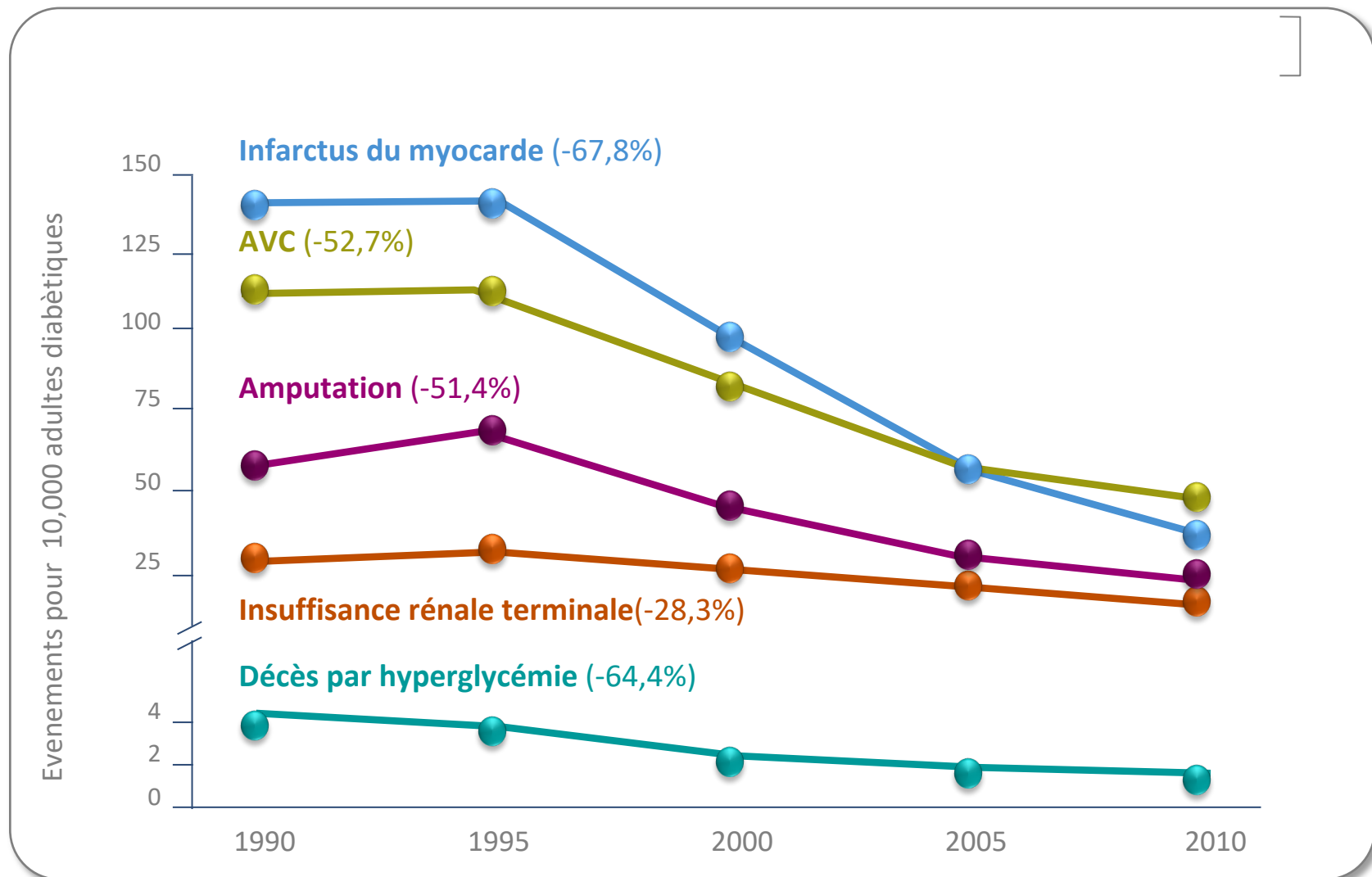
Niveau de Risque Cardio-Vasculaire dans le diabète de type 2



*p < 0,001 pour diabétiques vs non-diabétiques et ATCD IDM vs pas d'ATCD (Suivi ≈ 8 ans)

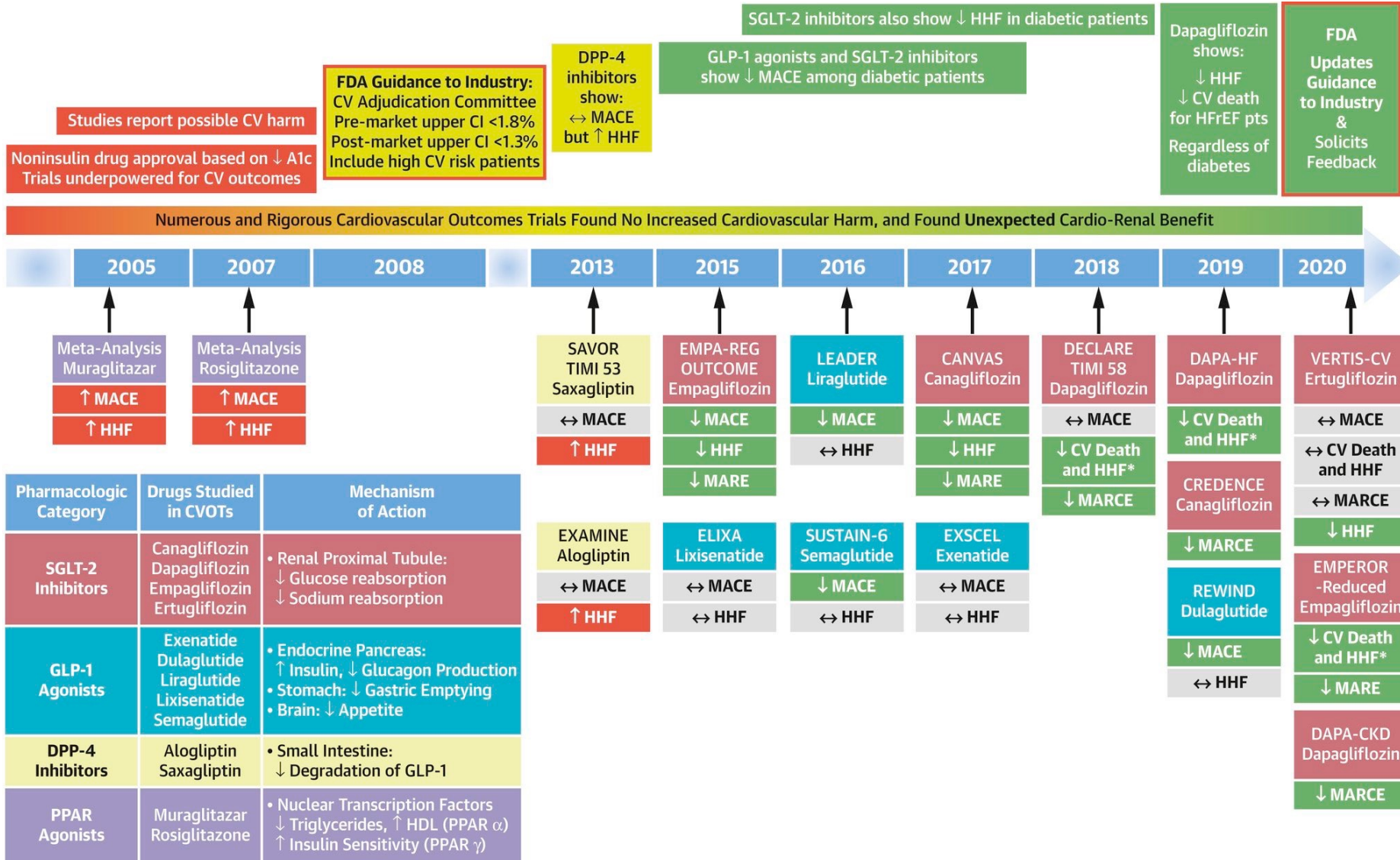
Facteurs de Risque Cardio-Vasculaires : Diabète

Evolution des complications liées au diabète



Facteurs de Risque Cardio-Vasculaires : Diabète

Les essais cliniques en diabétologie



Facteurs de Risque Cardio-Vasculaires : Diabète

Pourquoi faire baisser l'HbA1c ?

**Le contrôle glycémique intensif
diminue t'il le Risque Cardio-Vasculaire ?**

Étude ACCORD : *"Action to Control Cardiovascular Risk in Diabetes"*

Étude ADVANCE : *"Action in Diabetes and Vascular Disease"*

Étude VADT : *"Veterans Affairs Diabetes Trial"*

D'après : COMMUNICATION : Congrès American Diabetes Association 2008

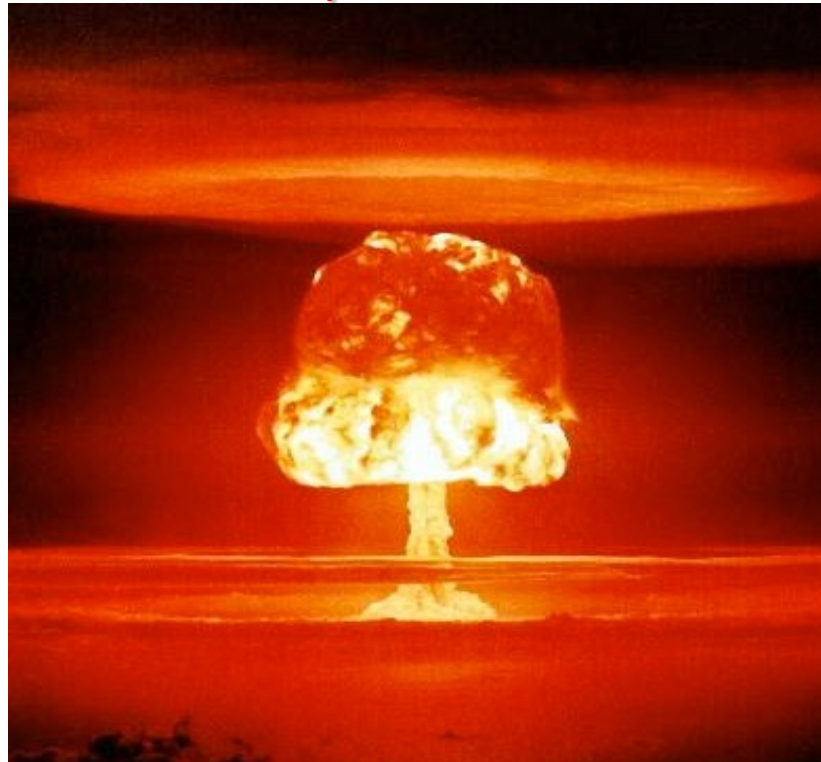
PUBLICATION : N Engl J Med : 12 juin 2008.

COMMUNICATION : Congrès American Diabetes Association 8 Juin 2008.

Facteurs de Risque Cardio-Vasculaires : Diabète

Pourquoi faire baisser l'HbA1c ?

**Le contrôle glycémique intensif
diminue t'il le Risque Cardio-Vasculaire ?**



NON !

D'après : COMMUNICATION : Congrès American Diabetes Association 2008

PUBLICATION : N Engl J Med : 12 juin 2008.

COMMUNICATION : Congrès American Diabetes Association 8 Juin 2008.

Facteurs de Risque Cardio-Vasculaires : Diabète

Intérêt des nouveaux traitements dans le diabète de type 2

2 Classes ont un intérêt particulier :

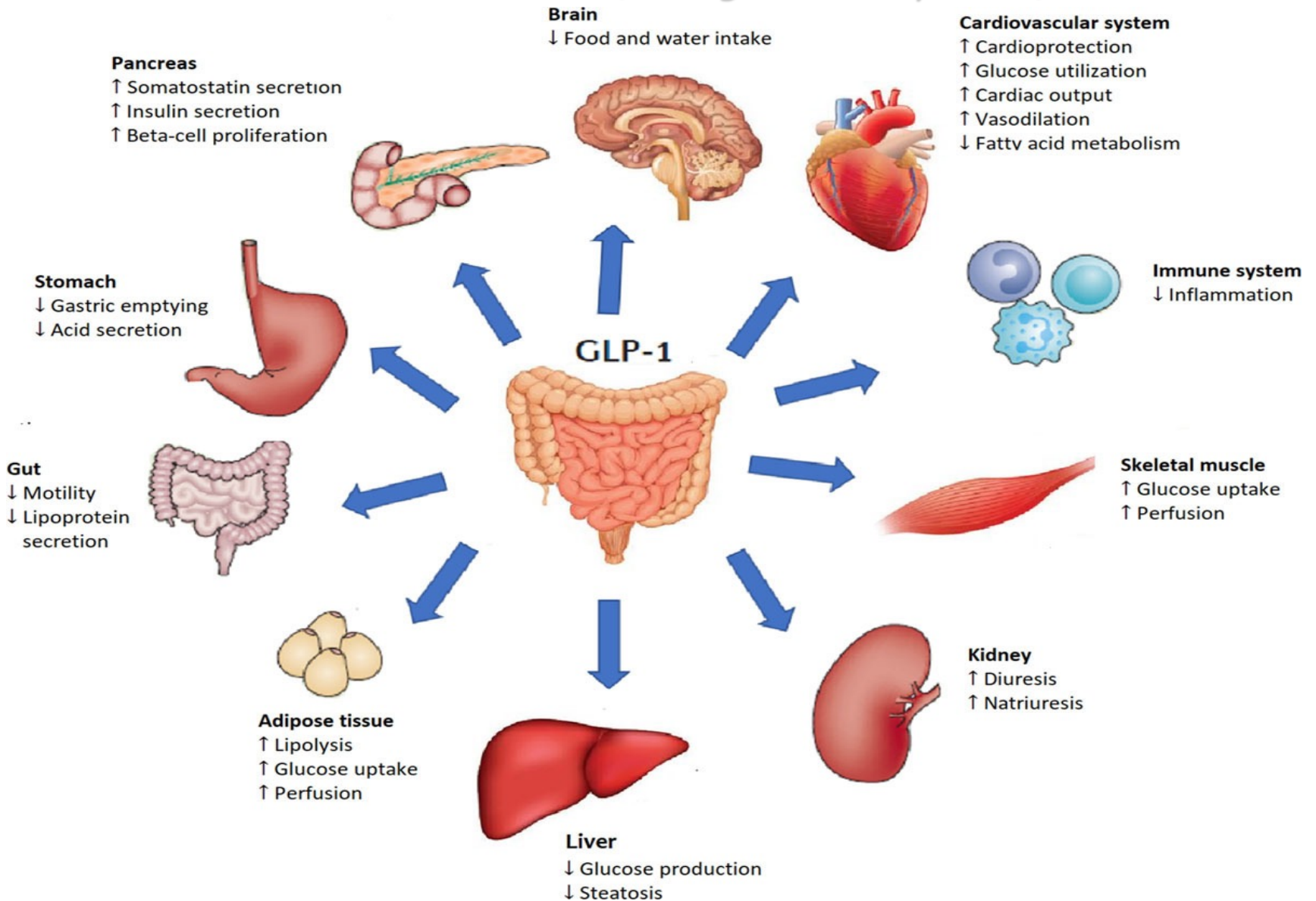
Les Analogues du GLP-1 (Glucagon Like Peptide 1)
(Étude LEADER : *Liraglutide* : 2018)

Les Inhibiteurs SGLT2 (Métabolisme Rénal du Glucose)
(Étude EMPAREG : *Empaglifozine* : 2018)

➡ Diminution des événements Cardio-Vasculaires

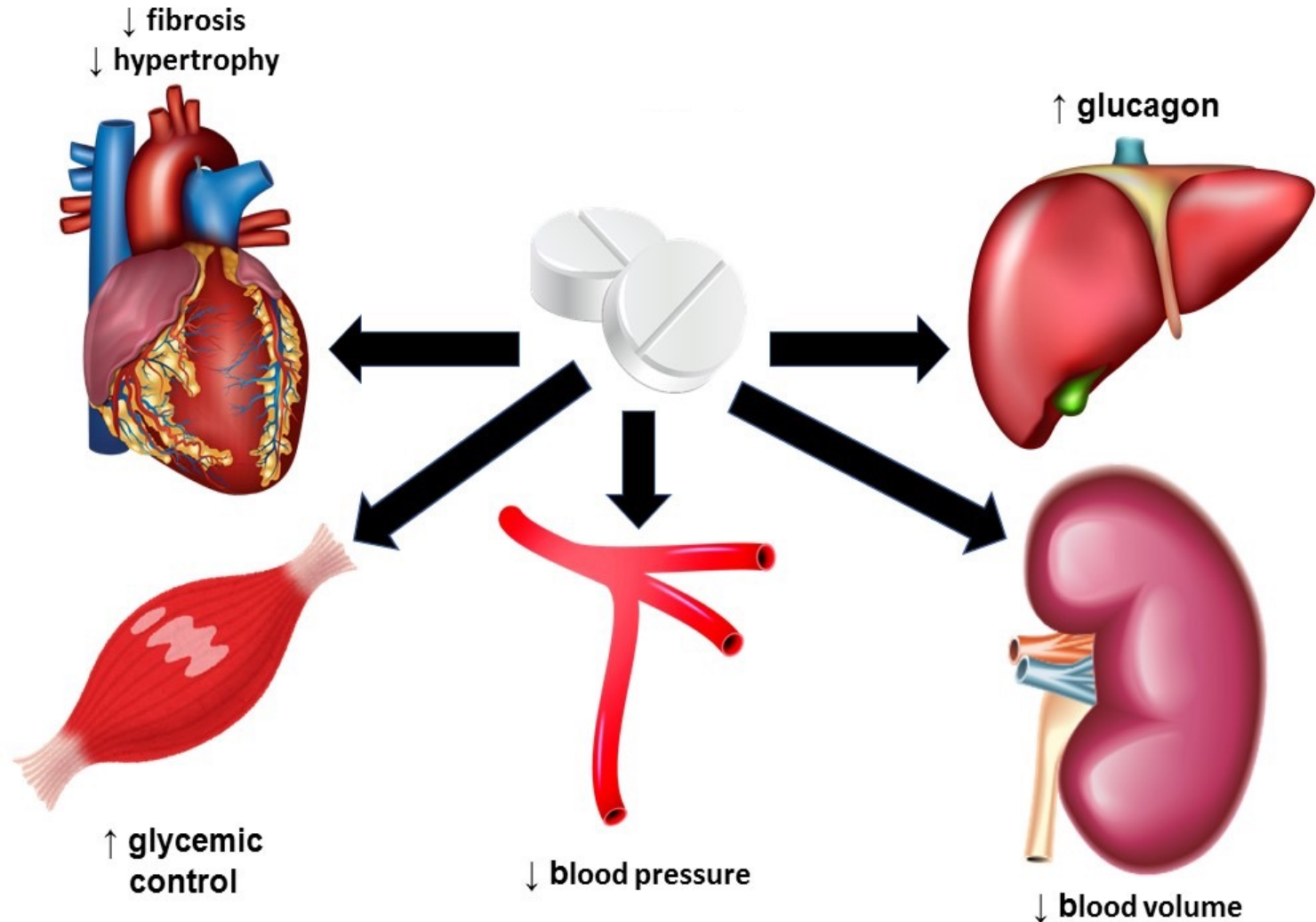
Facteurs de Risque Cardio-Vasculaires : Diabète

Effets des du GLP-1 (*Glucagon Like Peptide 1*)



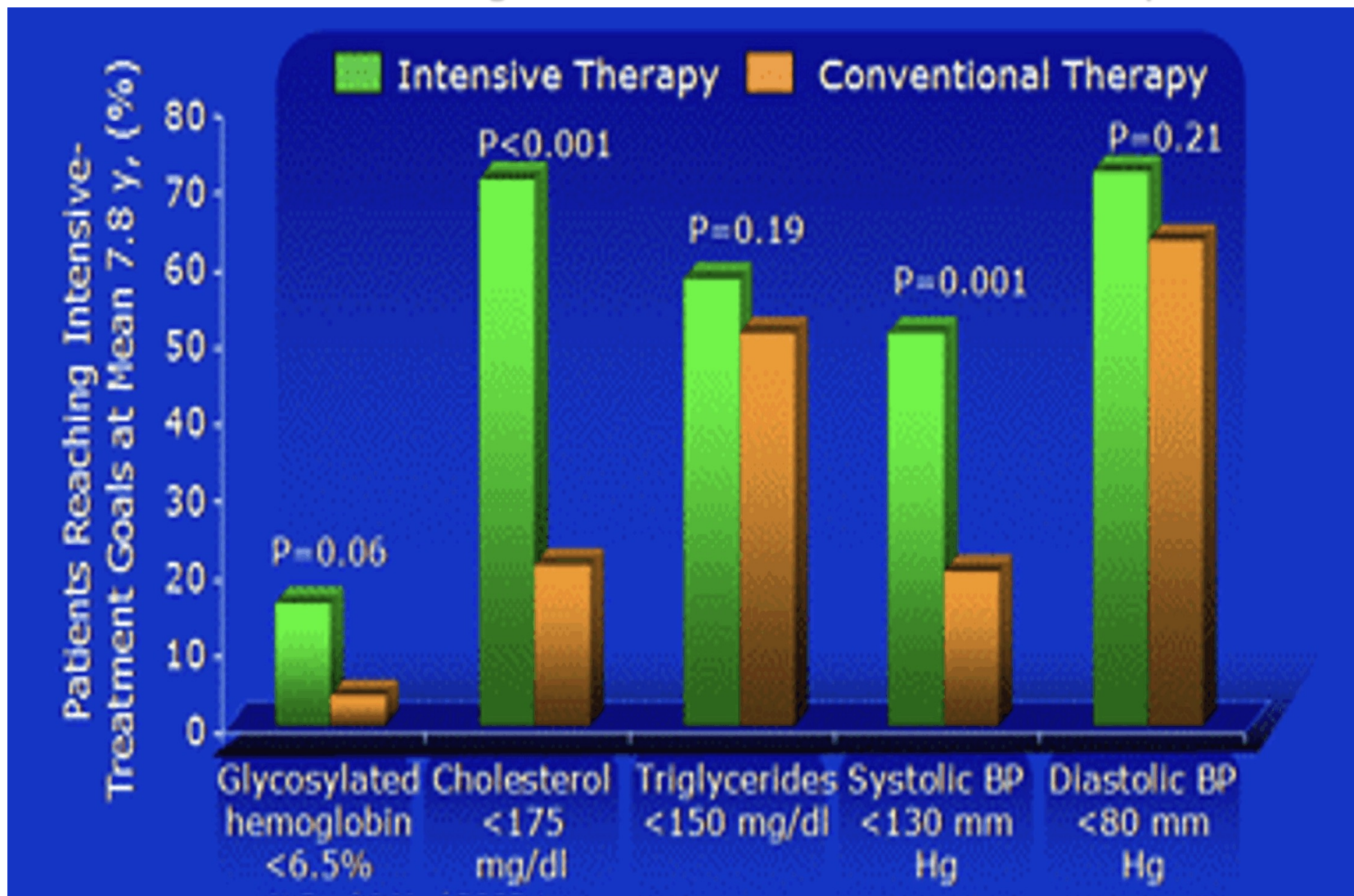
Facteurs de Risque Cardio-Vasculaires : Diabète

Effets des Inhibiteurs de SGLT 2 (Glifozines)



Facteurs de Risque Cardio-Vasculaires : Diabète

Efficacité de la Prise en Charge multifactorielle chez le diabétique : STENO 2

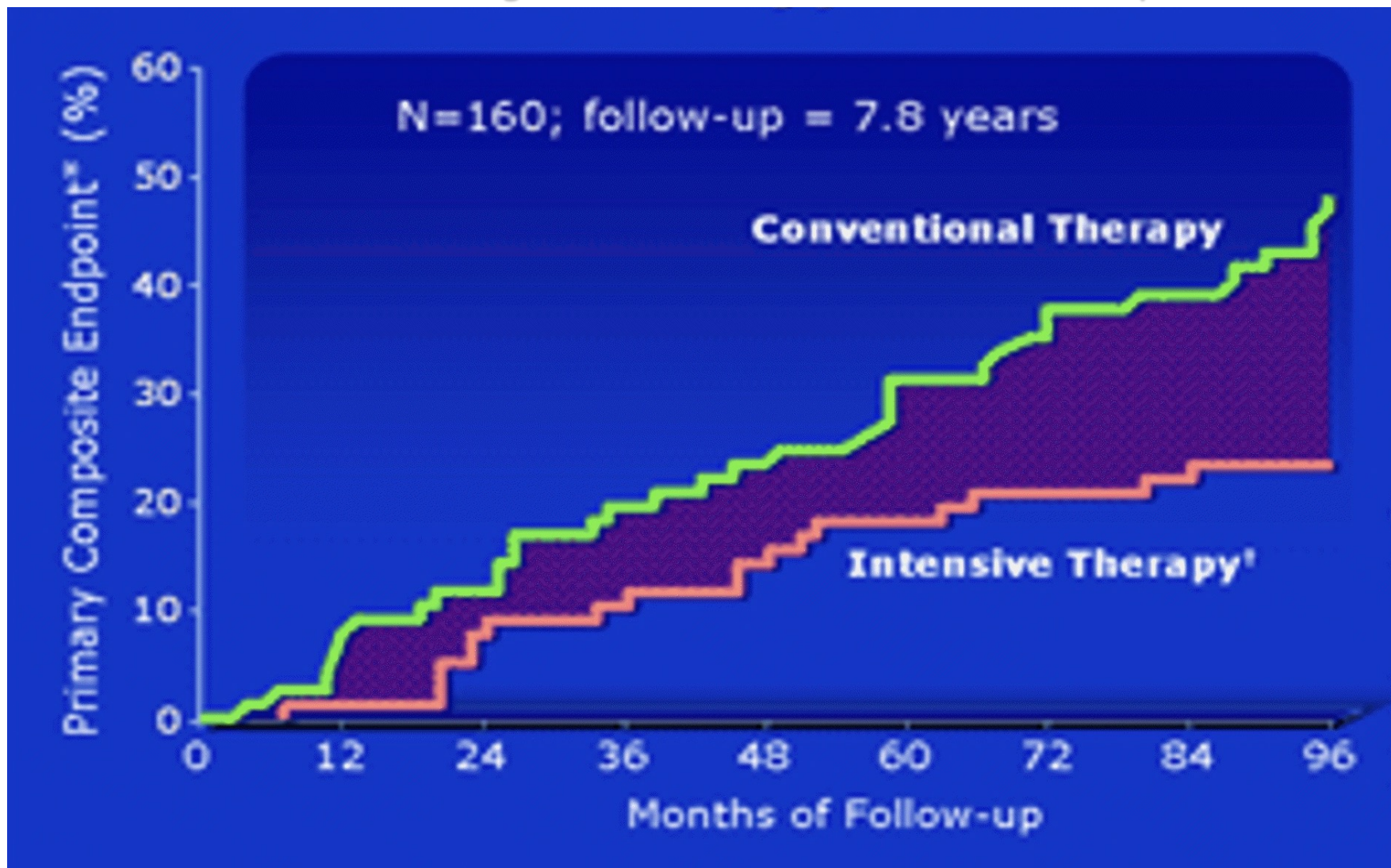


Prise en charge intensive versus conventionnelle dans le diabète de type 2

D'après Gaede P. et al : New England J Med 2003

Facteurs de Risque Cardio-Vasculaires : Diabète

Efficacité de la Prise en Charge multifactorielle chez le diabétique : STENO 2



- 20 % de réduction du Risque Absolu d'événements CV

D'après Gaede P. et al : New England J Med 2003

Facteurs de Risque Cardio-Vasculaires : Diabète

Et maintenant SCORE 2 DIABETE

Example: 60 year old non-smoking individual with diabetes, SBP = 140 mm Hg, total cholesterol = 5.5 mmol/L and HDL = 1.3 mmol/L



	Low risk region		Moderate risk region		High risk region		Very-high risk region	
	Man	Woman	Man	Woman	Man	Woman	Man	Woman
Newly diagnosed diabetes (i.e. at age 60), HbA1c of 50 mmol/mol, eGFR of 90 ml/min/1.73m ²	8.4%	6.1%	11.0%	7.6%	12.5%	11.1%	20.3%	20.6%
Diabetes diagnosed age 50, HbA1c of 70 mmol/mol, eGFR of 60 ml/min/1.73m ²	12.9%	9.8%	17.2%	12.7%	21.0%	20.4%	31.2%	34.0%

Facteurs de Risque Cardio-Vasculaires : Diabète

Diabète - Messages Clés

PATIENT DIABÉTIQUE = HAUT RISQUE CARDIO-VASCULAIRE

PRISE EN CHARGE DE L'ENSEMBLE DES FACTEURS DE RISQUE

NÉCESSITÉ D'UNE "POLYCHIMIOTHÉRAPIE"

INTÉRÊT DES MOLÉCULES CARDIO ET NÉPHRO PROTECTRICES

OBJECTIF RAISONNABLE :

➡ HbA1c < 7 %

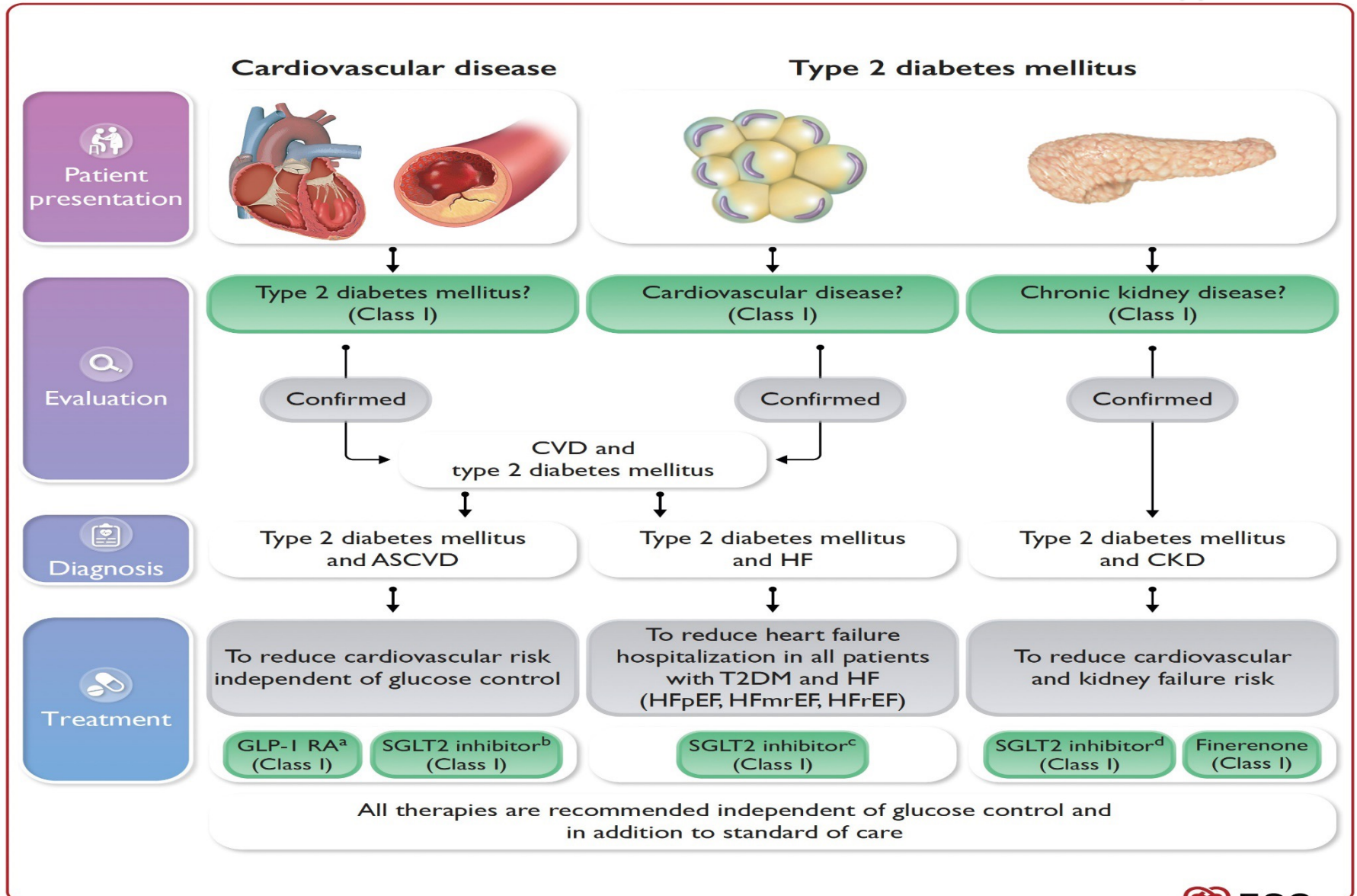
2023 ESC Guidelines for the management of cardiovascular disease in patients with diabetes

Developed by the task force on the management of cardiovascular disease in patients with diabetes of the European Society of Cardiology (ESC)

Authors/Task Force Members: Nikolaus Marx  *[†], (Chairperson) (Germany), Massimo Federici  *[†], (Chairperson) (Italy), Katharina Schütt  [‡], (Task Force Co-ordinator) (Germany), Dirk Müller-Wieland  [‡], (Task Force Co-ordinator) (Germany), Ramzi A. Ajjan  (United Kingdom), Manuel J. Antunes  (Portugal), Ruxandra M. Christodorescu (Romania), Carolyn Crawford (United Kingdom), Emanuele Di Angelantonio  (United Kingdom/Italy), Björn Eliasson  (Sweden), Christine Espinola-Klein (Germany), Laurent Fauchier (France), Martin Halle  (Germany), William G. Herrington  (United Kingdom), Alexandra Kautzky-Willer  (Austria), Ekaterini Lambrinou  (Cyprus), Maciej Lesiak  (Poland), Maddalena Lettino  (Italy), Darren K. McGuire  (United States of America), Wilfried Mullens (Belgium), Bianca Rocca  (Italy), Naveed Sattar  (United Kingdom), and ESC Scientific Document Group

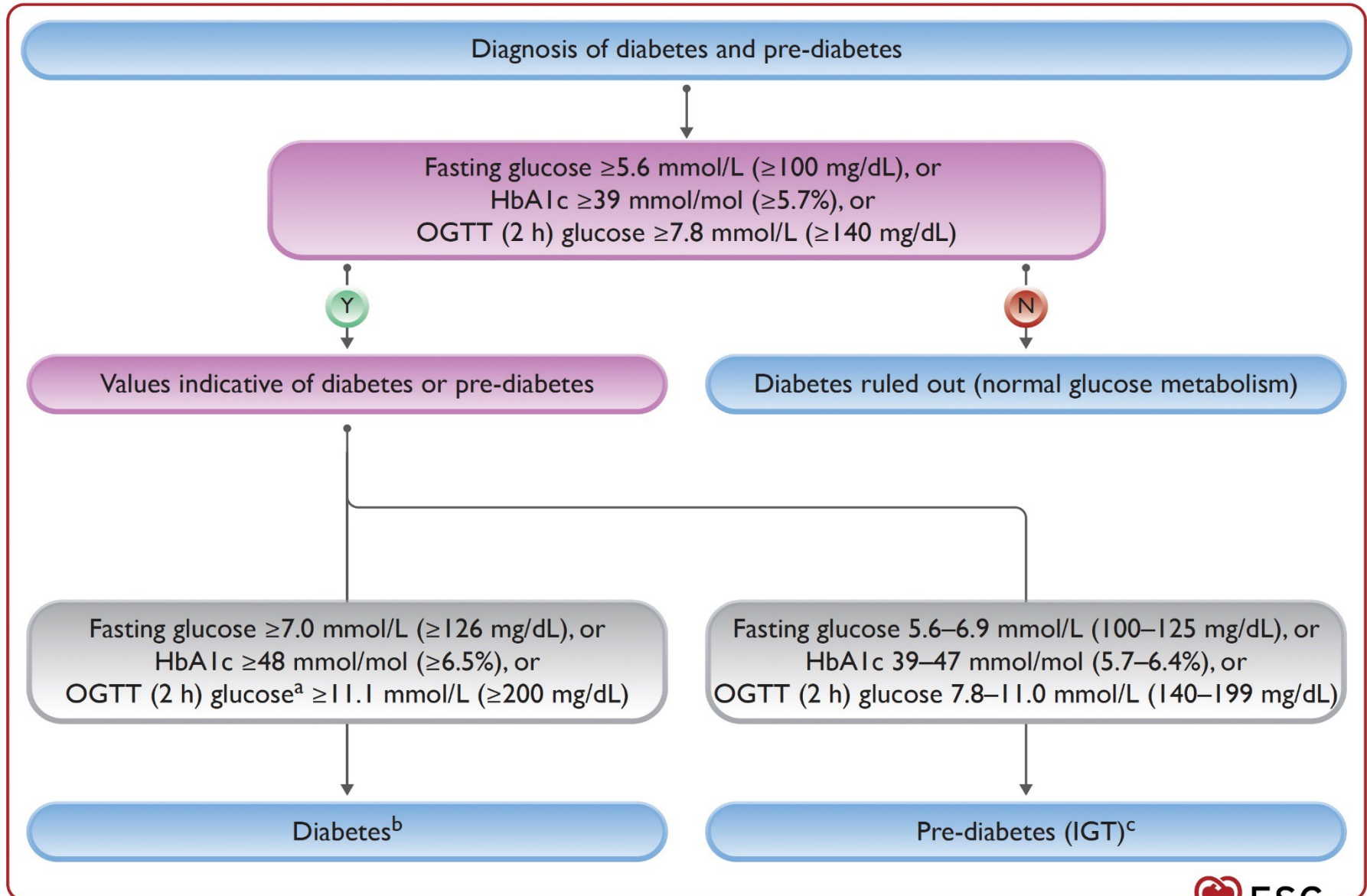
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Gestion des Maladies Cardio-Vasculaires dans le diabète de type 2



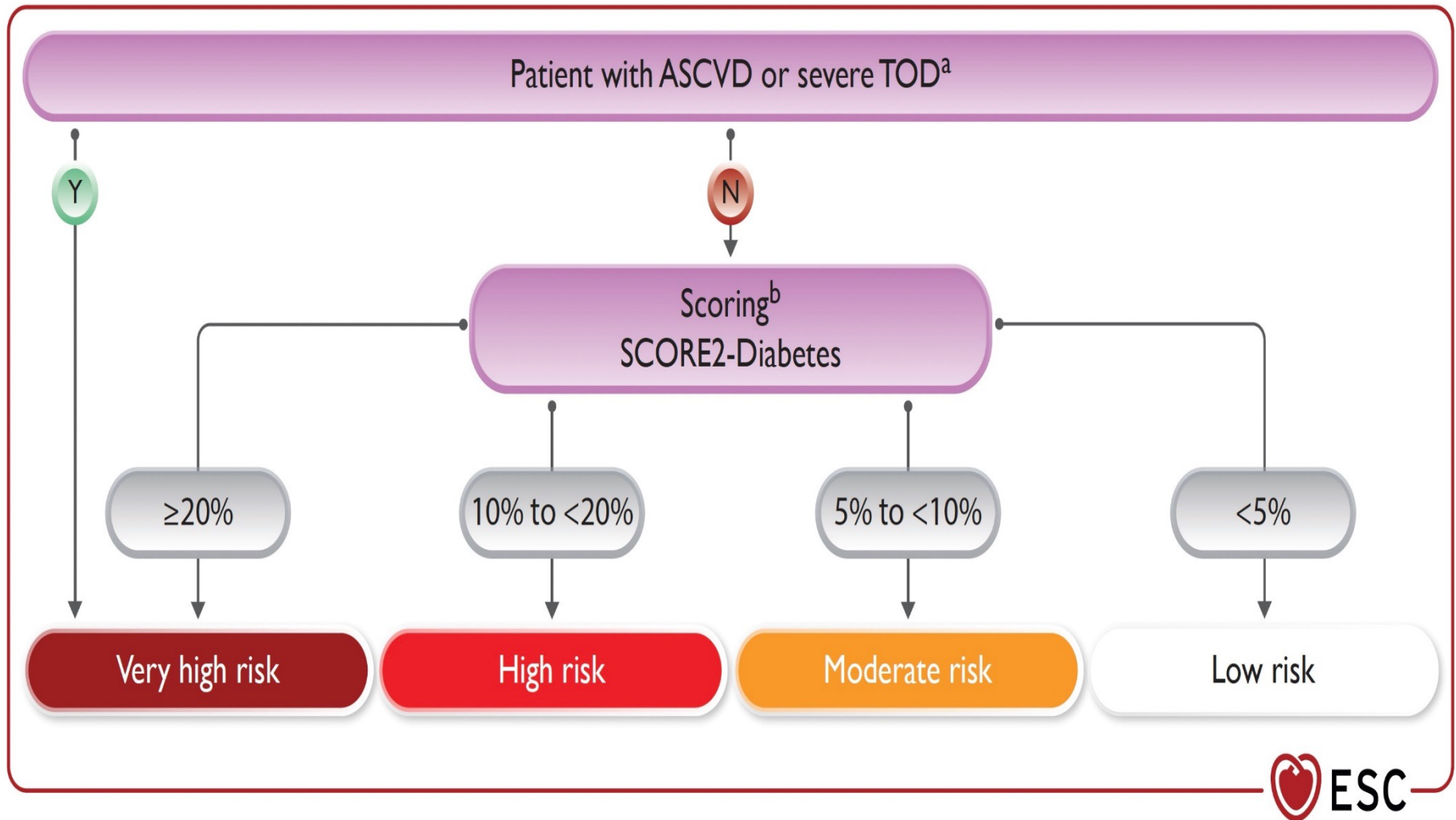
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Diagnostic du diabète et du pré-diabète



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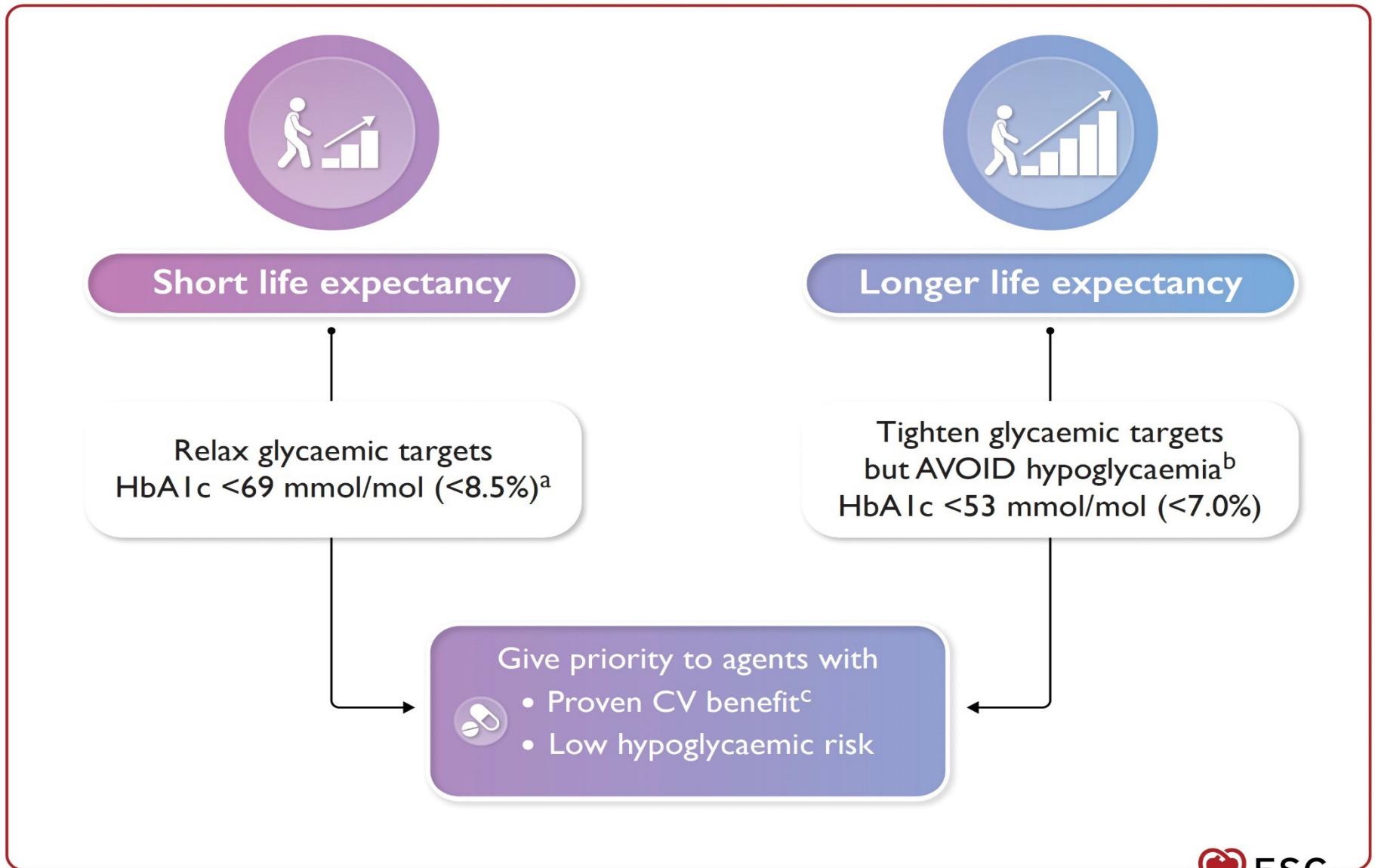
Catégories de Risque Cardio-Vasculaire dans le diabète de type 2



ASCVD : Atherosclerotic Cardio Vascular Disease
TOD : Target Organ Damage

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Guide pour les cibles glycémiques pour les patients avec diabète de type 2



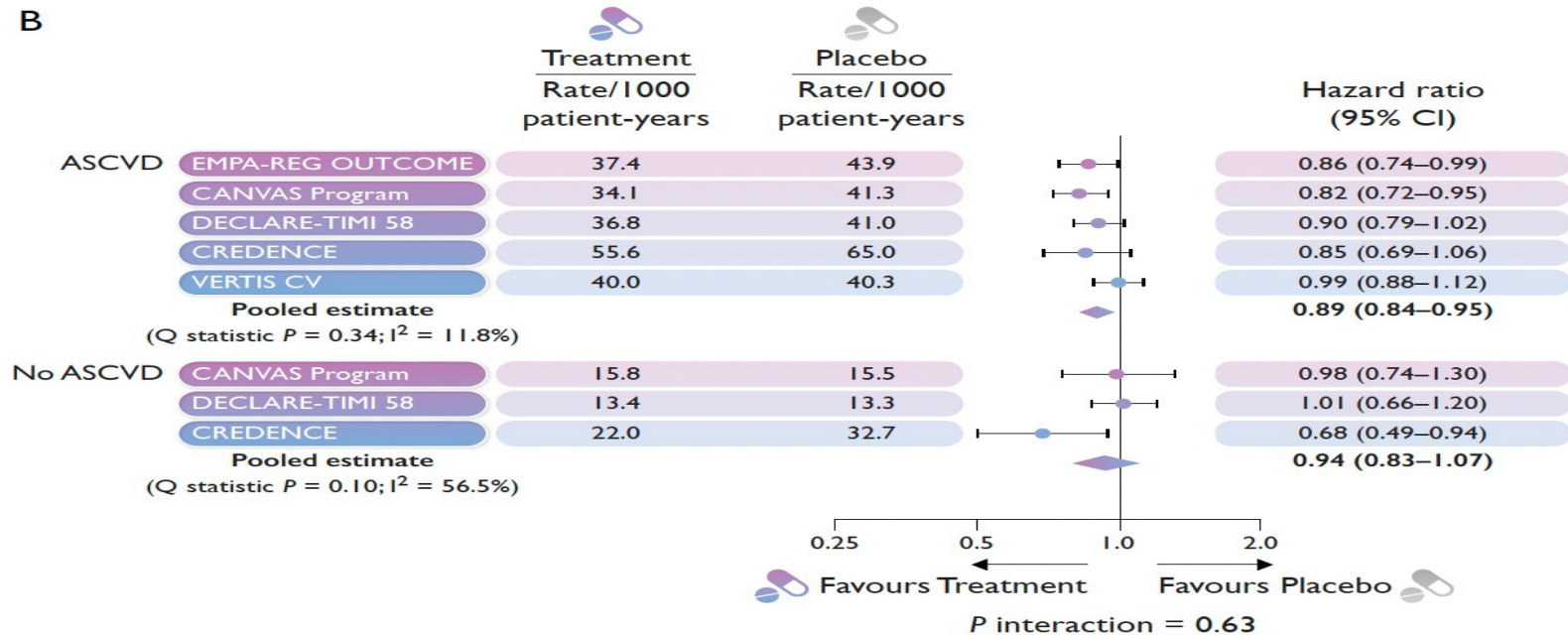
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Méta-analyse des événements CV avec les iSGLT2 chez les diabétiques

A

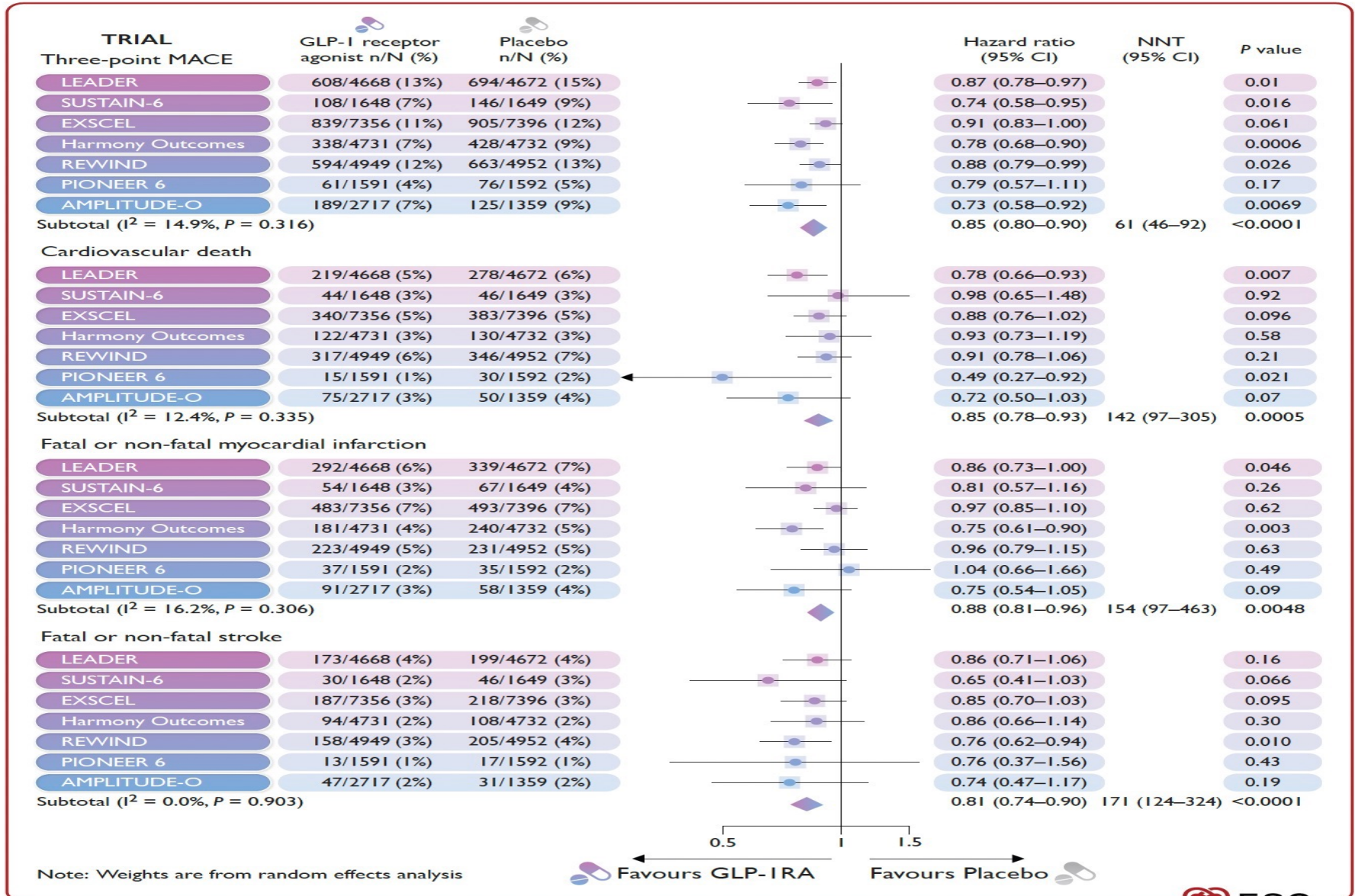


B



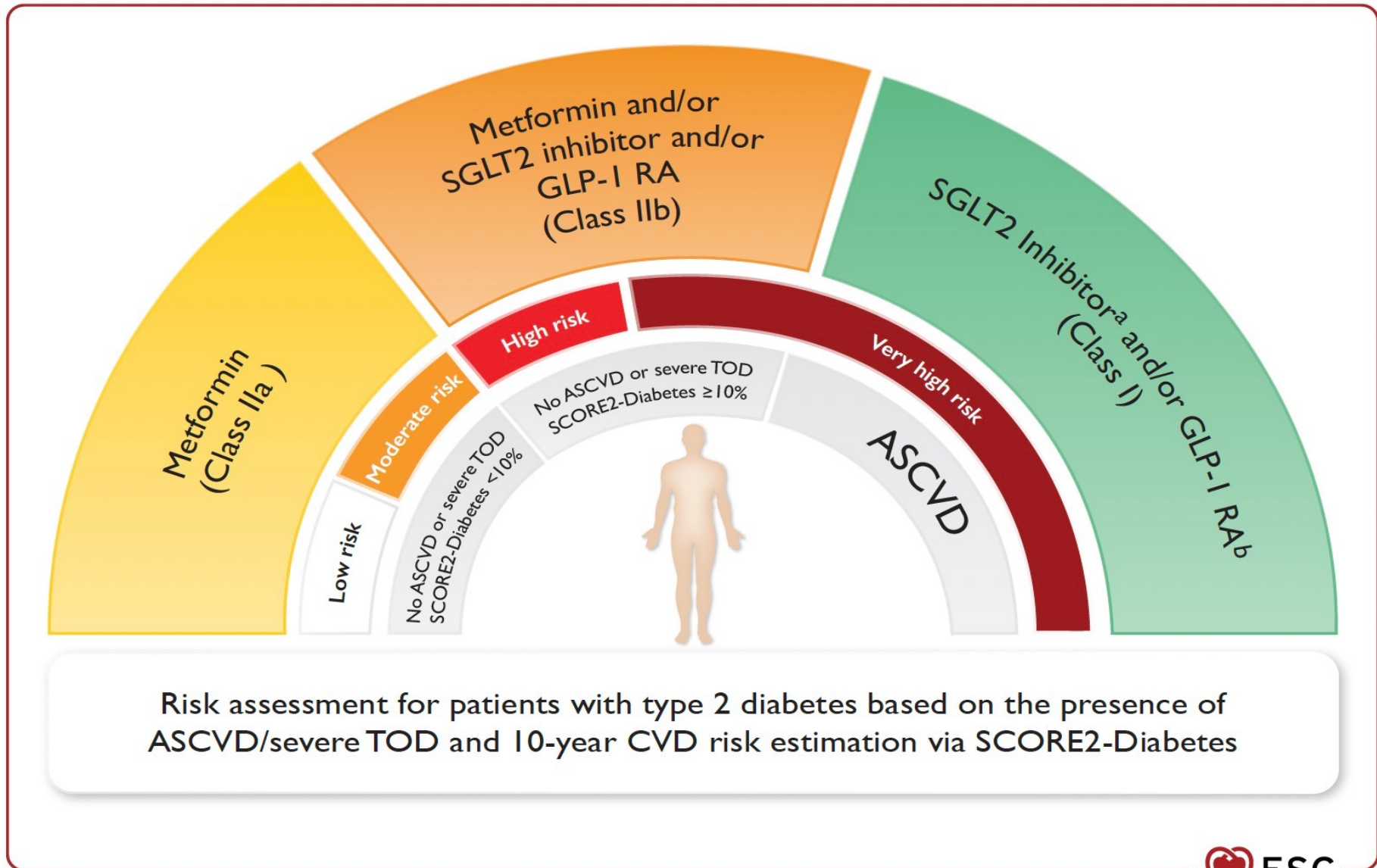
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Méta-analyse des événements CV avec les agonistes GLP1 chez les diabétiques



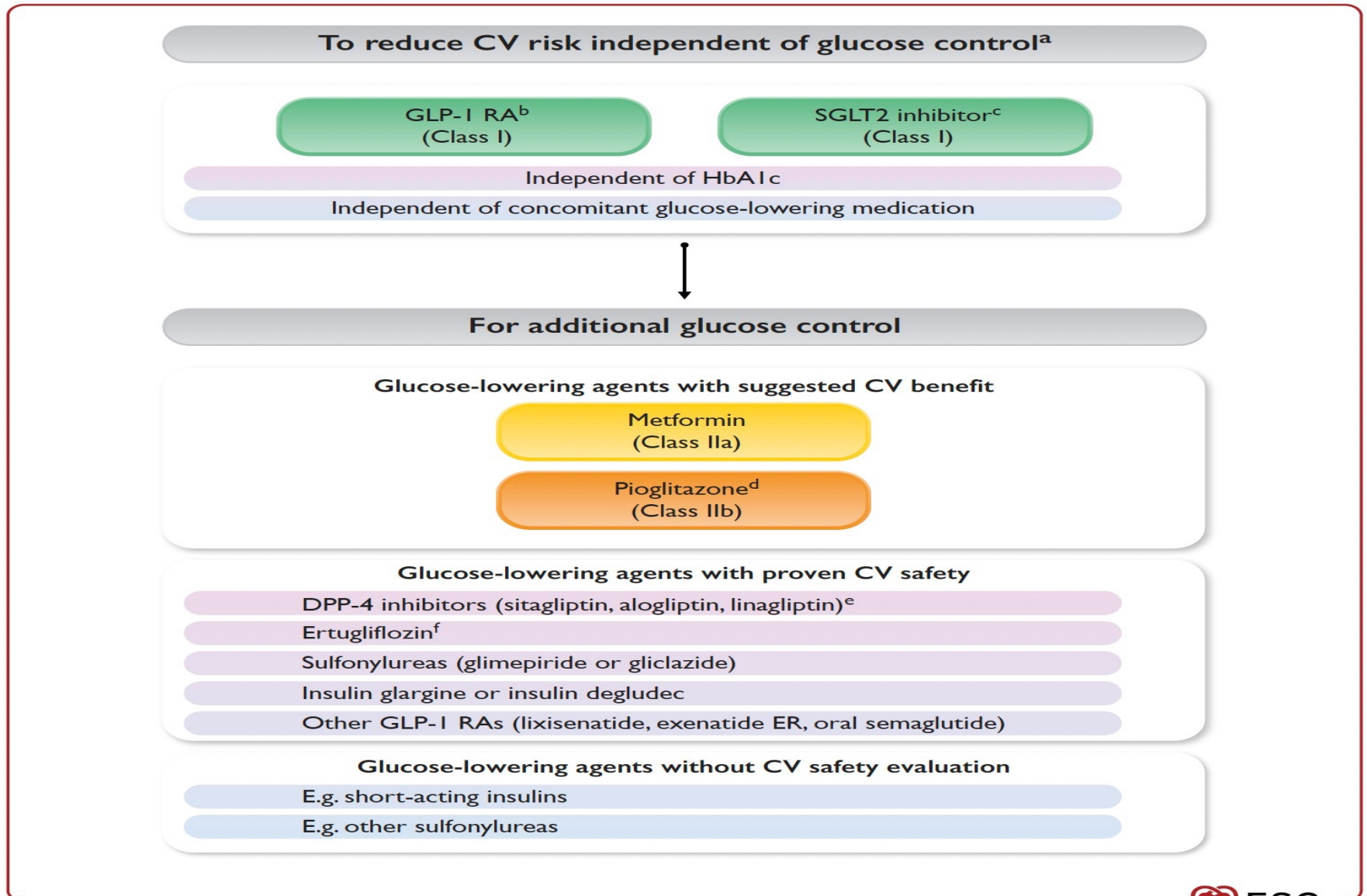
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Les traitements hypoglycémiants pour la réduction du RCV



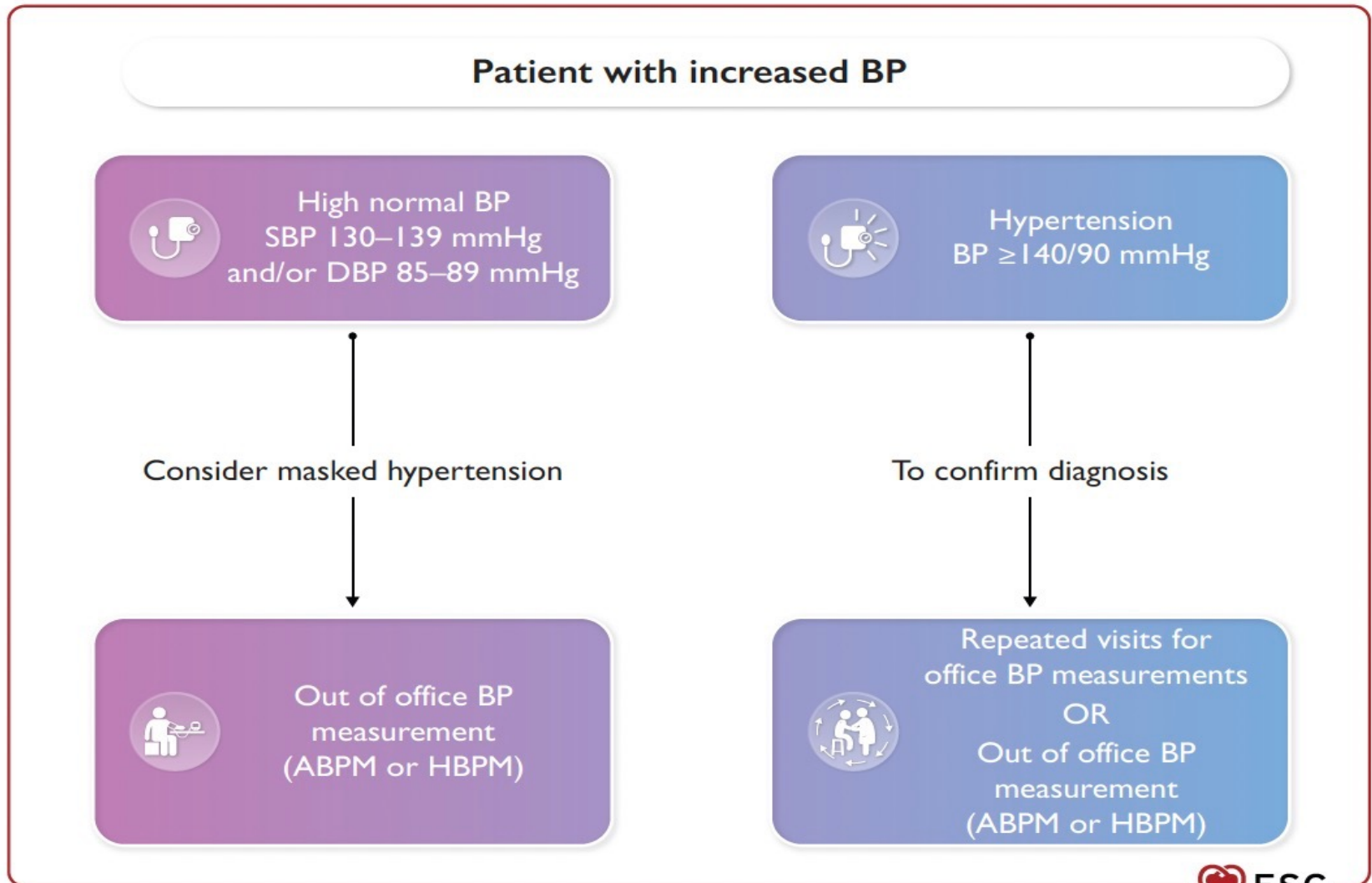
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Les traitements hypoglycémifiants pour réduction du RCV et contrôle glycémique



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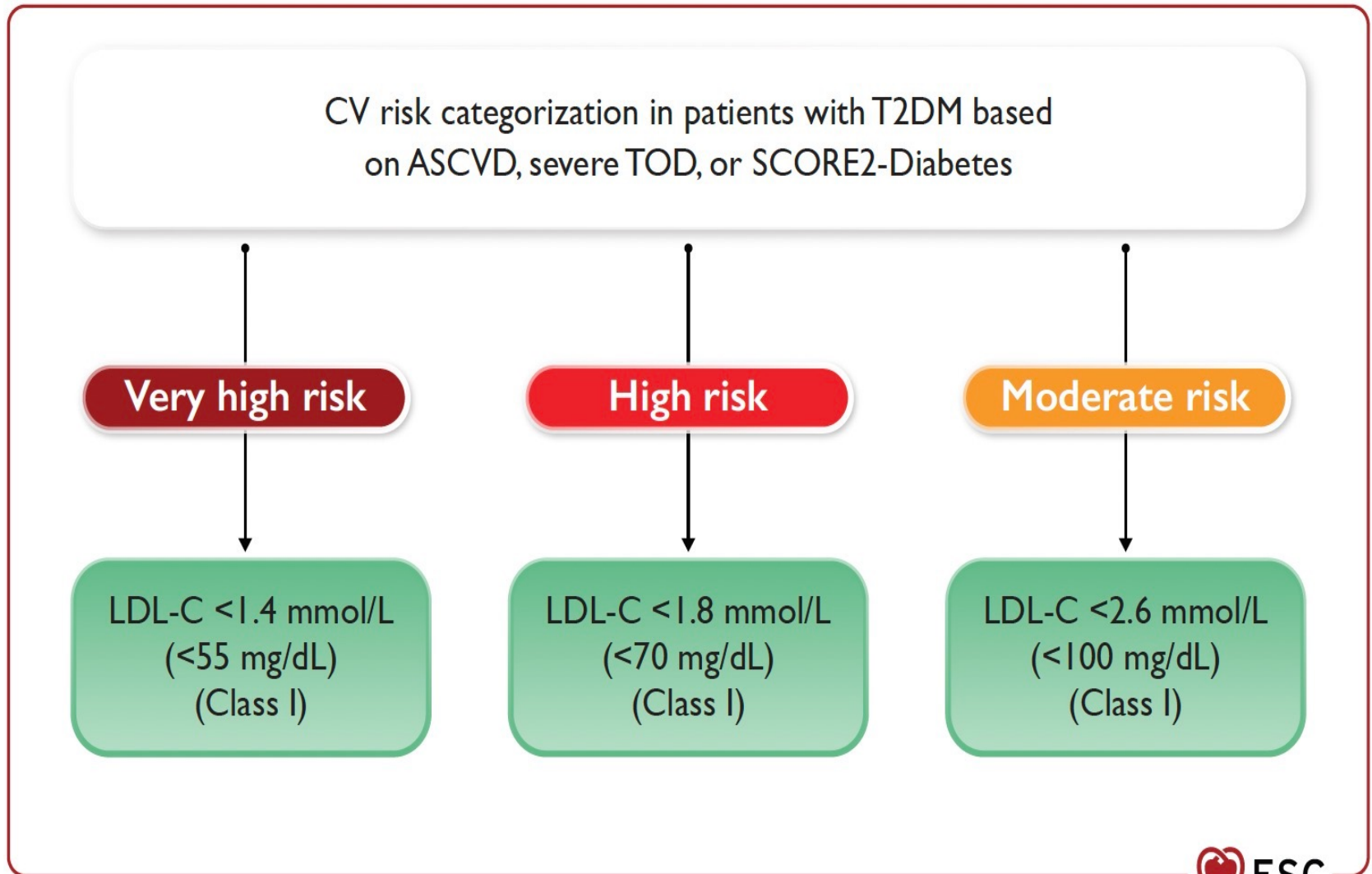
Dépistage et diagnostic de l'HTA chez le patient diabétique



ABPM : Ambulatory Blood Pressure Monitoring
HBPM : Home Blood Pressure Monitoring

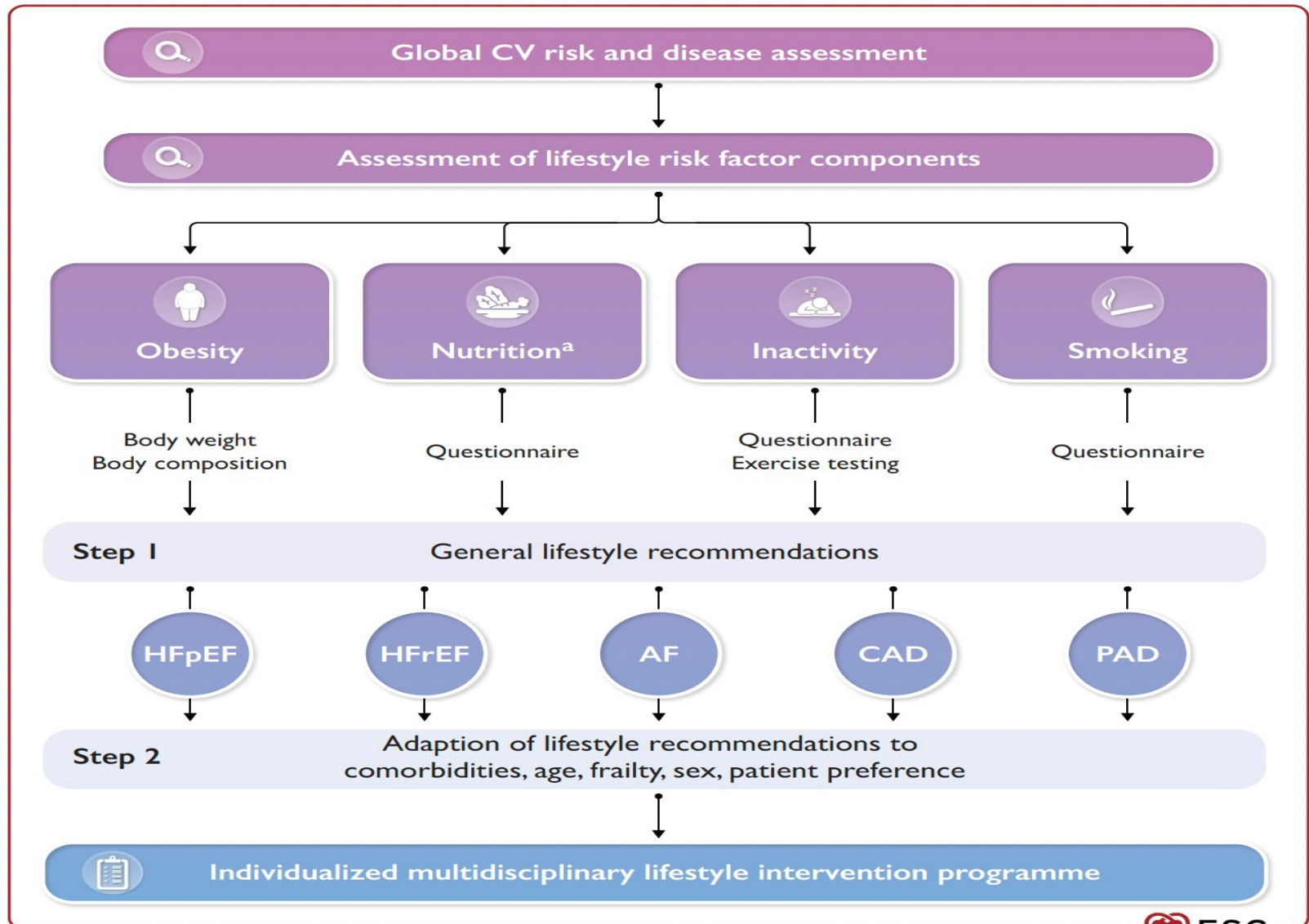
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Cibles de LDL-Cholestérol en fonction du risque chez le patient diabétique



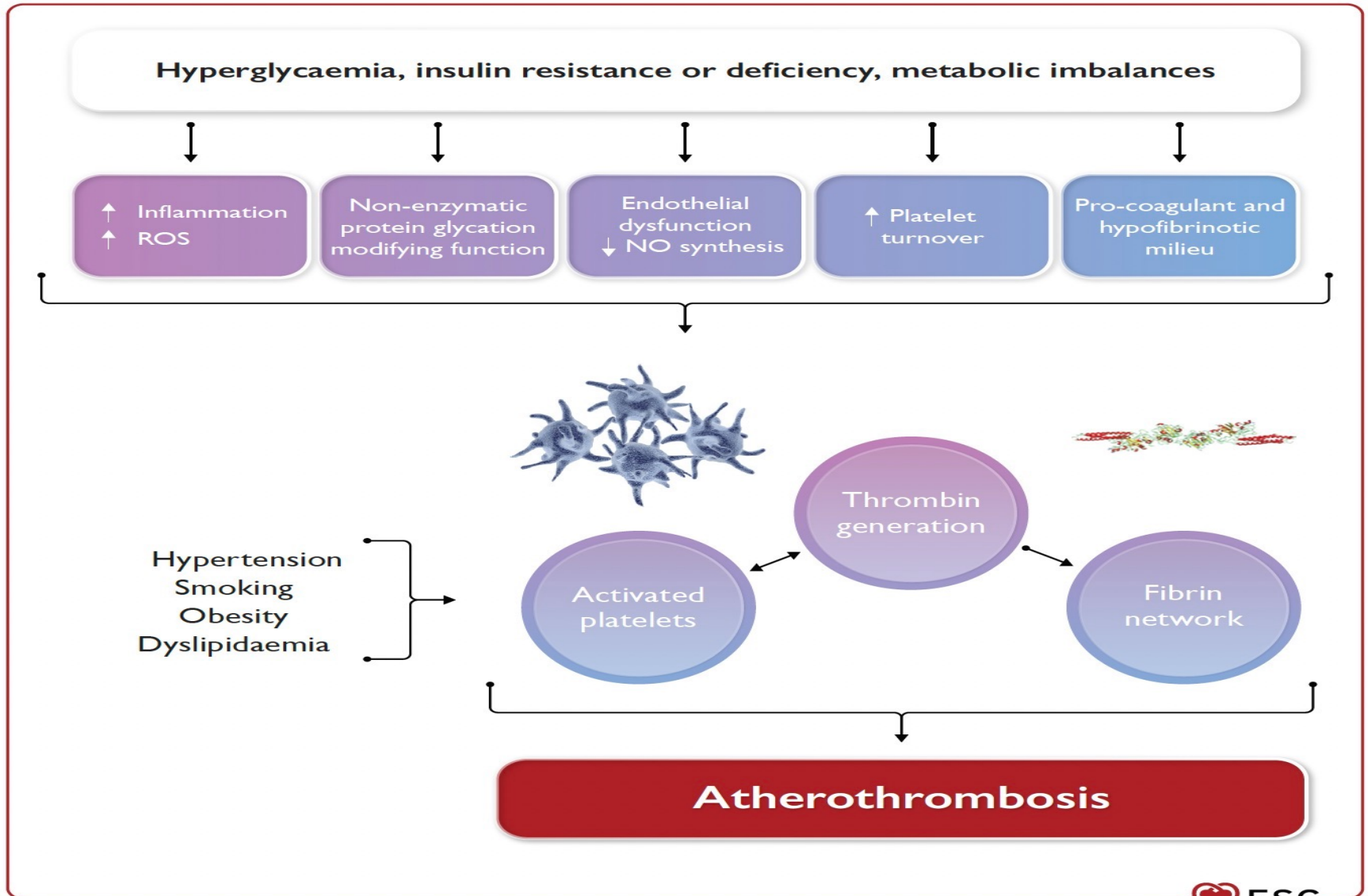
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Évaluation et Prise en Charge des facteurs liés au style de vie



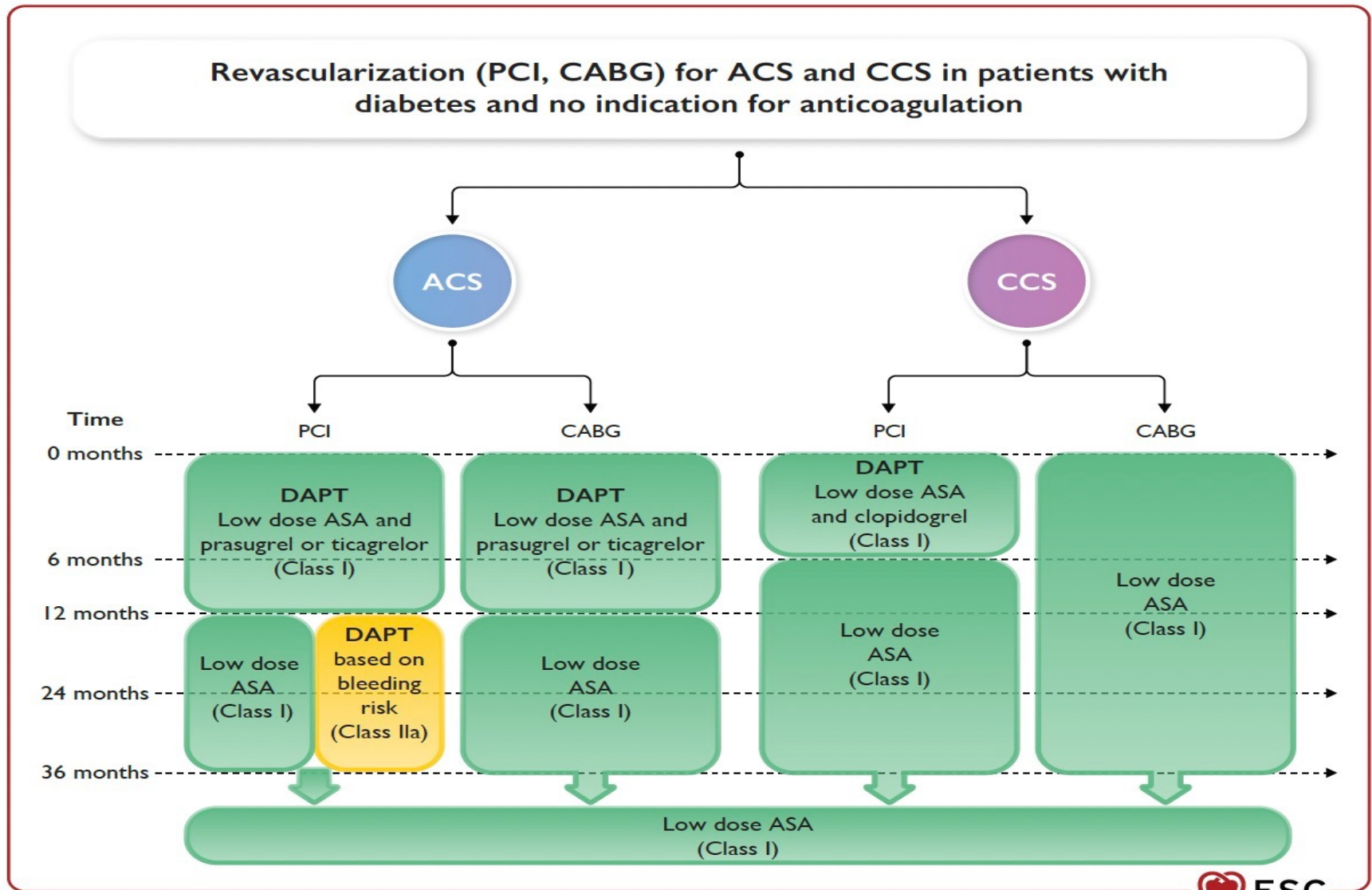
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Mécanismes de l'activation plaquettaire et athérothrombose chez le diabétique



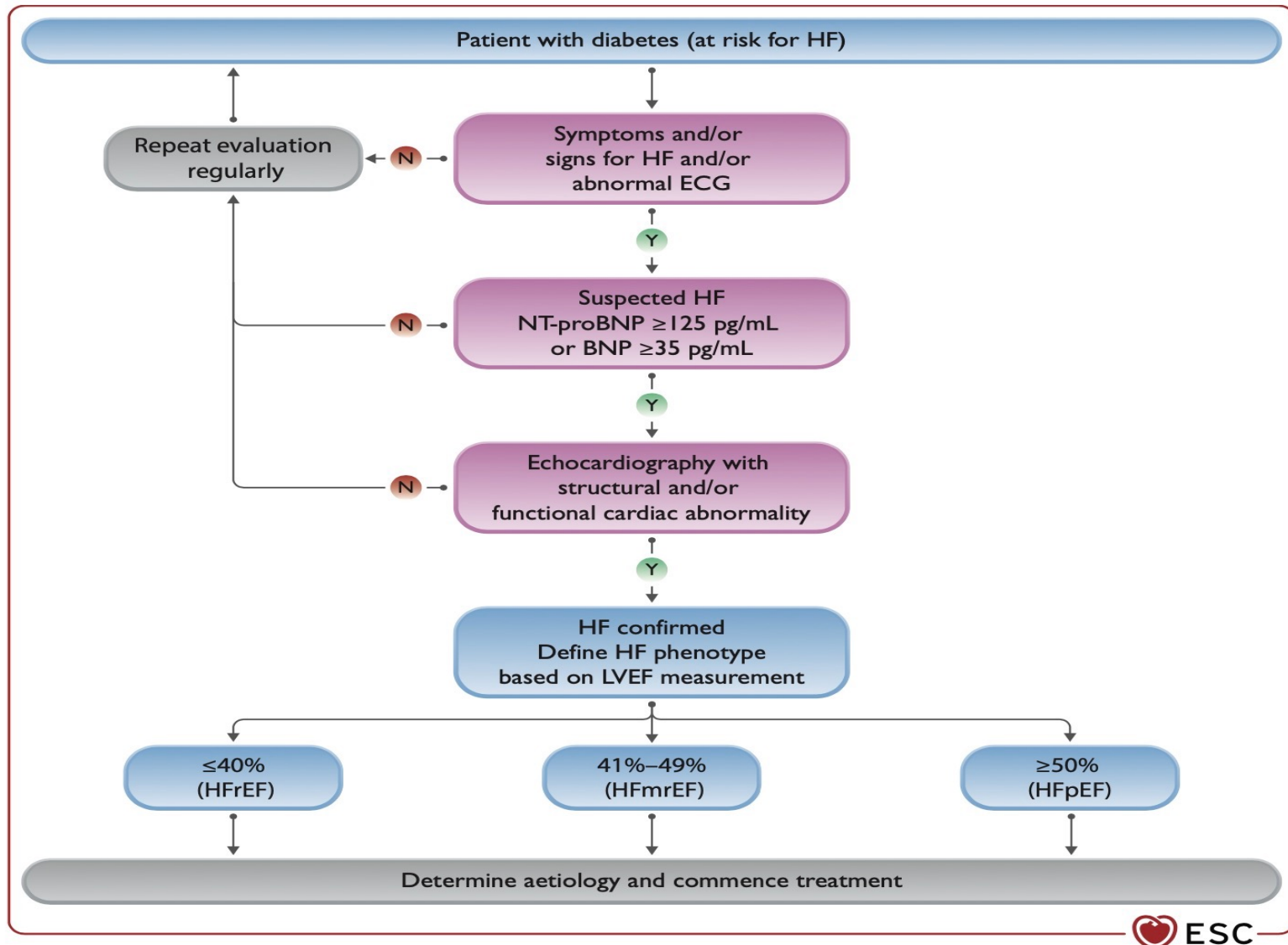
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Traitement antiplaquettaire et coronaropathie



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Algorithme diagnostique de l'insuffisance cardiaque chez les patients diabétiques

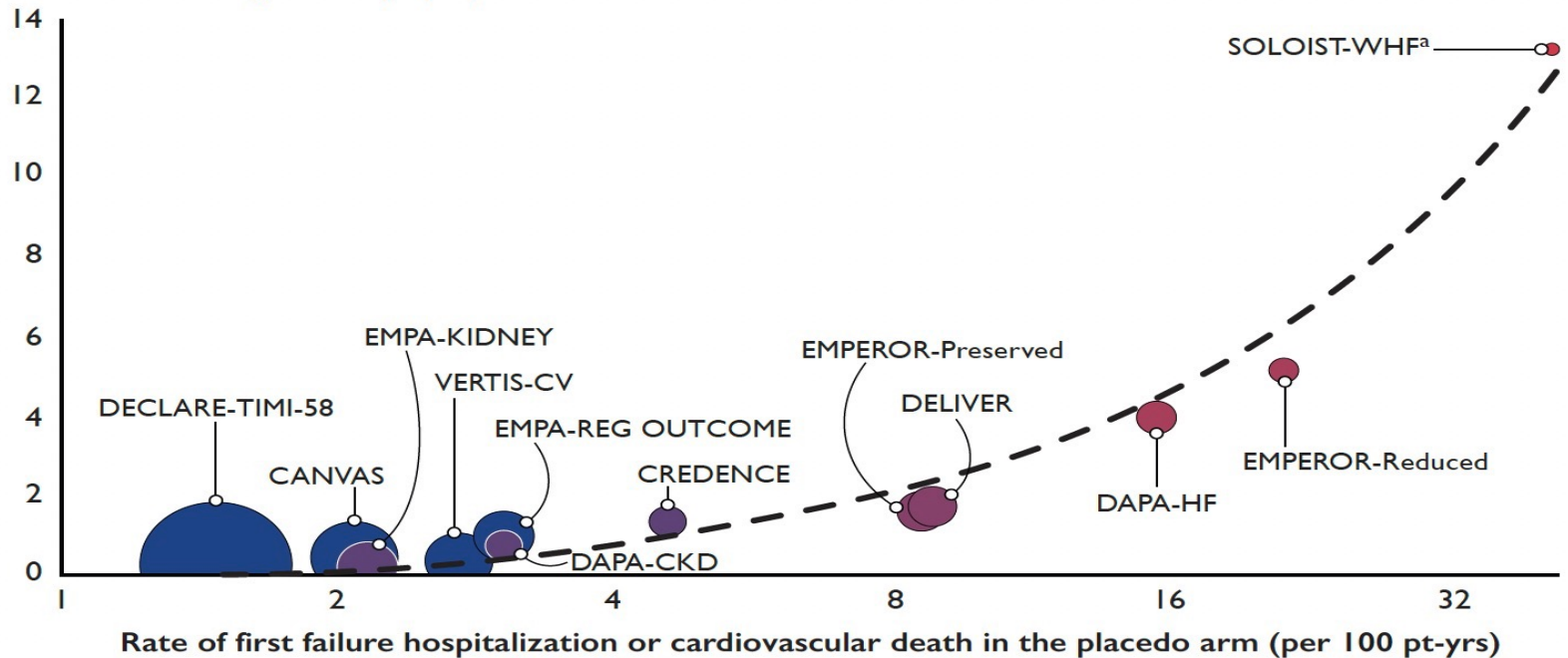


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Réduction du risque d'insuffisance cardiaque avec les iSGLT2

High risk T2DM	CKD	Chronic HFpEF	Chronic HFrEF	Worsening HF
ARR: 0.25–1.04 per 100 pt-yrs	ARR: 0.80–1.39 per 100 pt-yrs	ARR: 1.8 per 100 pt-yrs	ARR: 3.9–5.2 per 100 pt-yrs	ARR: 10.4 per 100 pt-yrs
NNT: 96–400 RRR: 12%–34%	NNT: 72–125 RRR: 29%–31%	NNT: 59 RRR: 21%	NNT: 21–36 RRR: 25%	NNT: 10 RRR: 129%

Absolute risk reduction with SGLT2 inhibitors (per 100 pt-yrs)



Prise en Charge du Diabète - Recommandations ESC 2023

Risque d'insuffisance cardiaque avec les hypoglycémiants

To reduce HF-related outcomes^a in all patients with T2DM and HF (HFpEF, HFmrEF, HFrEF)

SGLT2 inhibitor^b
(Class I)

Independent of HbA1c

Independent of concomitant glucose-lowering medication



For additional glucose control

Other glucose-lowering agents with neutral effects on HF in CVOTs should be considered

GLP-1 RA^c
(Class IIa)

Sitagliptin
Linagliptin
(Class IIa)

Metformin
(Class IIa)

Insulin glargine
Insulin degludec
(Class IIa)

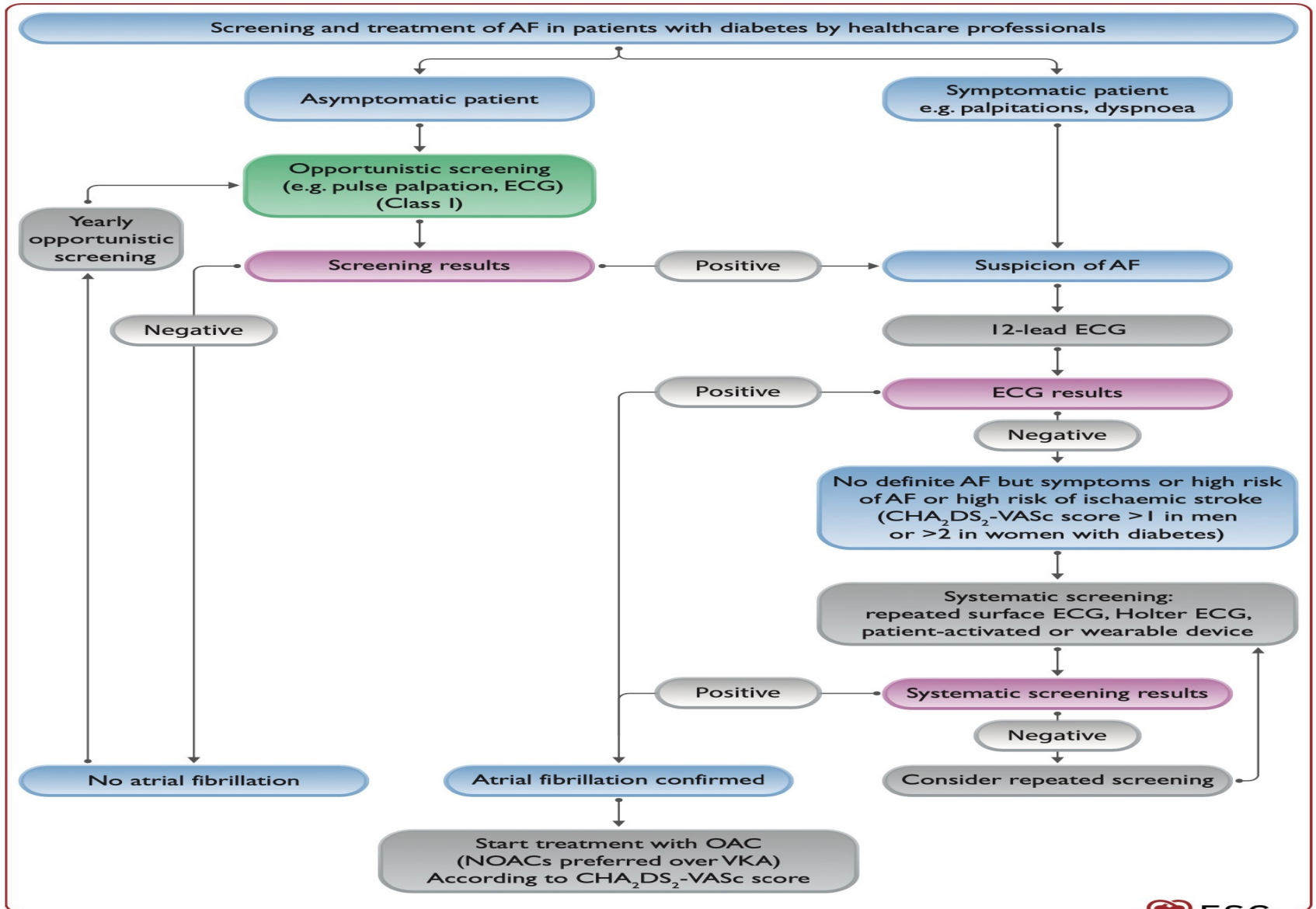
Other glucose-lowering agents with increased risk for HF hospitalization in CVOTs are not recommended

Pioglitazone
(Class III)

Saxagliptin
(Class III)

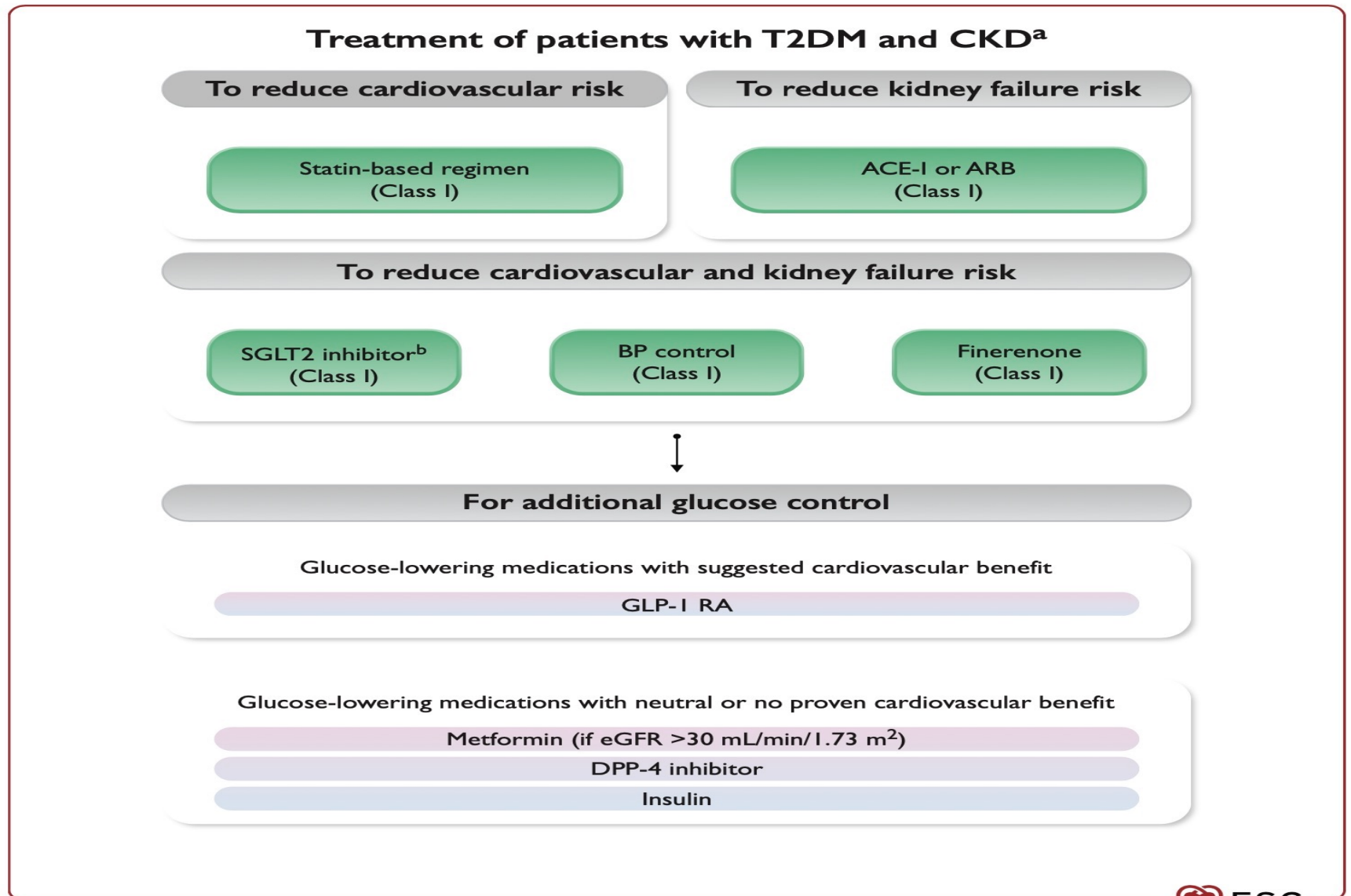
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Algorithme diagnostique de la Fibrillation Atriale chez les patients diabétiques



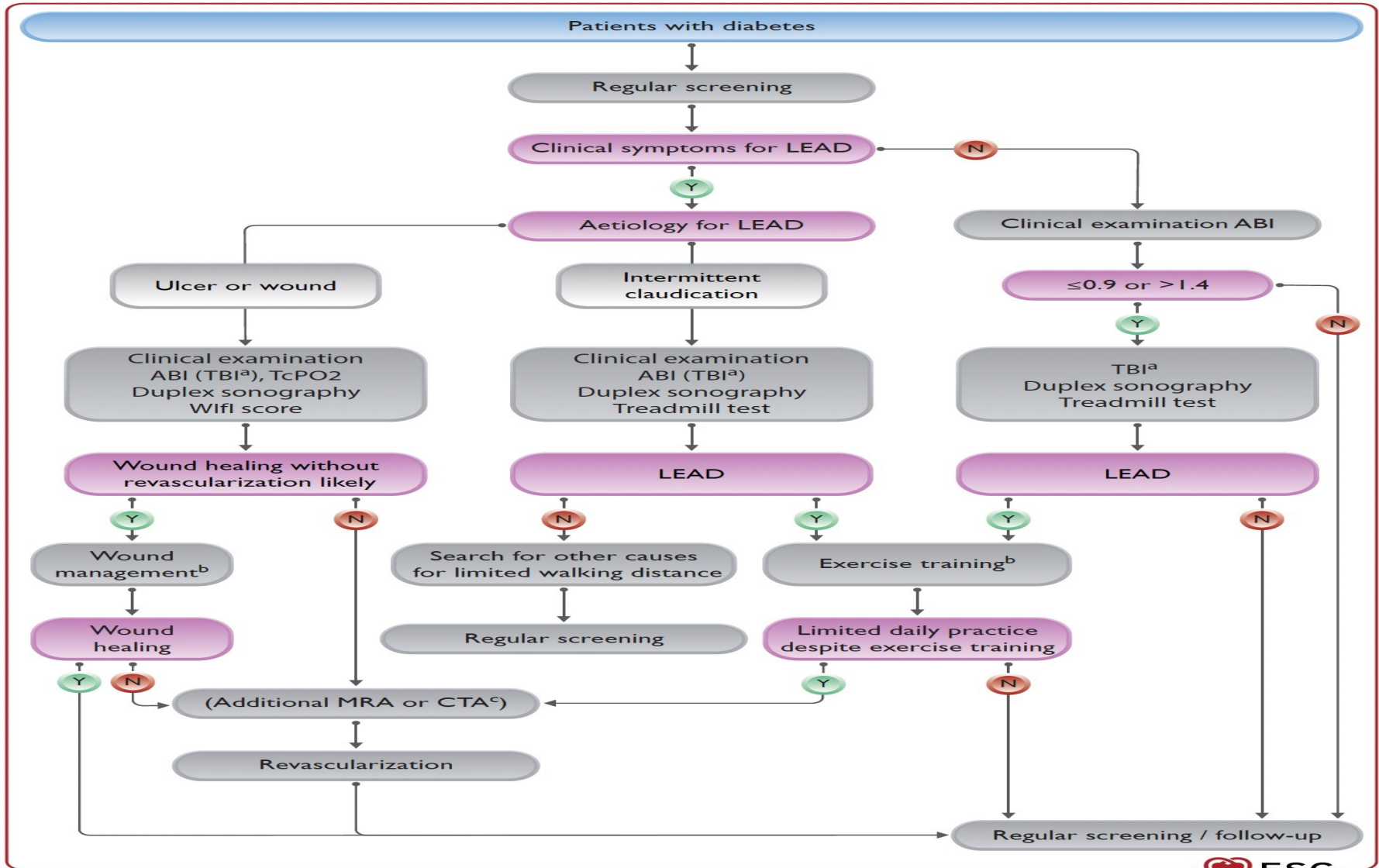
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Traitement des patients diabétiques avec insuffisance rénale



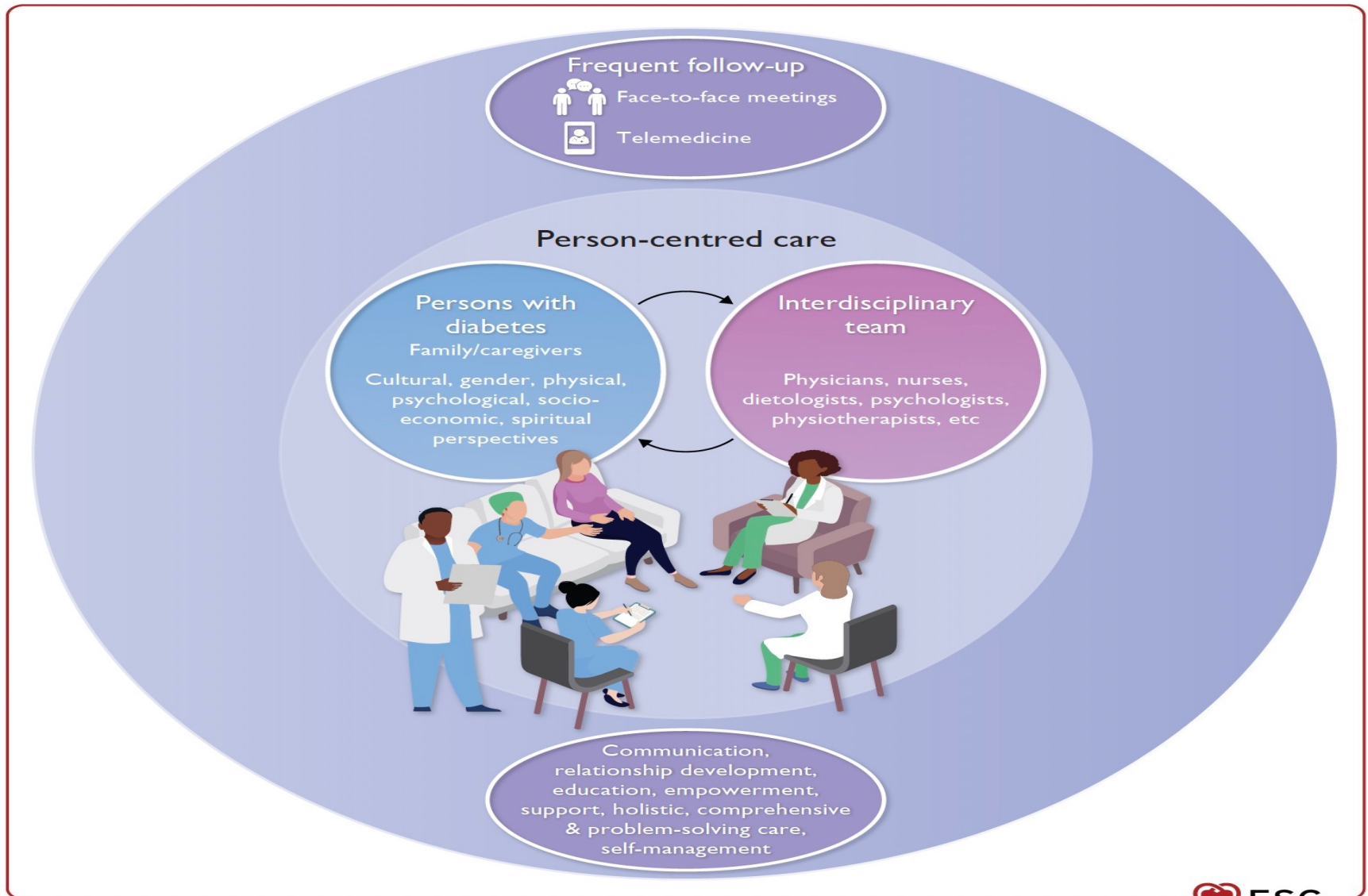
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Diagnostic et Prise en Charge de l'AOMI chez le diabétique



Prise en Charge du Diabète - Recommandations ESC 2023

Prise en Charge « centrée sur le patient » chez le diabétique



Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for diagnosis of diabetes

Screening for diabetes is recommended in all individuals with CVD, using fasting glucose and/or HbA1c.

I

A

It is recommended that the diagnosis of diabetes is based on HbA1c and/or fasting plasma glucose, or on an OGTT if still in doubt.

I

B

Recommendations for assessing cardiovascular risk in patients with diabetes

It is recommended to screen patients with diabetes for the presence of severe TOD.

I

A

It is recommended to assess medical history and the presence of symptoms suggestive of ASCVD in patients with diabetes.

I

B

In patients with T2DM without symptomatic ASCVD or severe TOD, it is recommended to estimate 10-year CVD risk via SCORE2-Diabetes.

I

B

Diagnostic et évaluation du Risque Cardio-Vasculaire

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for weight reduction in patients with diabetes		
It is recommended that individuals living with overweight or obesity aim to reduce weight and increase physical exercise to improve metabolic control and overall CVD risk profile.	I	A
Recommendations for nutrition in patients with diabetes		
It is recommended to adopt a Mediterranean or plant-based diet with high unsaturated fat content to lower cardiovascular risk.	I	A
Recommendation for physical activity/exercise in patients with diabetes		
It is recommended to increase any physical activity (e.g. 10 min daily walking) in all patients with T2DM with and without CVD. Optimal is a weekly activity of 150 min of moderate intensity or 75 min of vigorous endurance intensity.	I	A
It is recommended to adapt exercise interventions to T2DM-associated comorbidities, e.g. frailty, neuropathy, or retinopathy.	I	B
It is recommended to introduce structured exercise training in patients with T2DM and established CVD, e.g. CAD, HFpEF, HFmrEF, HFrEF, or AF to improve metabolic control, exercise capacity and quality of life, and to reduce CV events.	I	B
It is recommended to perform resistance exercise in addition to endurance exercise at least twice a week.	I	B
Recommendation for smoking cessation in patients with diabetes		
It is recommended to stop smoking to reduce cardiovascular risk.	I	A

Mode de vie

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for glycaemic targets

It is recommended to apply tight glycaemic control (HbA1c <7%) to reduce microvascular complications.

I

A

It is recommended to avoid hypoglycaemia, particularly in patients with CVD.

I

B

It is recommended to individualize HbA1c targets according to comorbidities, diabetes duration, and life expectancy.

I

C

Recommendations for glucose-lowering treatment for patients with type 2 diabetes and atherosclerotic cardiovascular disease to reduce cardiovascular risk

It is recommended to prioritize the use of glucose-lowering agents with proven CV benefits followed by agents with proven CV safety over agents without proven CV benefit or proven CV safety.

I

C

Sodium-glucose co-transporter-2 inhibitors

SGLT2 inhibitors with proven CV benefit are recommended in patients with T2DM and ASCVD to reduce CV events, independent of baseline or target HbA1c and independent of concomitant glucose-lowering medication.

I

A

Glucagon-like peptide-1 receptor agonists

GLP-1 RAs with proven CV benefit are recommended in patients with T2DM and ASCVD to reduce CV events, independent of baseline or target HbA1c and independent of concomitant glucose-lowering medication.

I

A

Cible glycémique et Molécules à privilégier

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for blood pressure in patients with diabetes

Screening for hypertension

Regular BP measurements are recommended in all patients with diabetes to detect and treat hypertension to reduce CV risk.

I

A

Treatment targets

Anti-hypertensive drug treatment is recommended for people with diabetes when office BP is $\geq 140/90$ mmHg.

I

A

It is recommended to treat hypertension in patients with diabetes in an individualized manner. The BP goal is to target SBP to 130 mmHg and < 130 mmHg if tolerated, but not < 120 mmHg. In older people (age > 65 years), it is recommended to target SBP to 130–139 mmHg.

I

A

Treatment and evaluation

Lifestyle changes (weight loss if overweight, physical activity, alcohol restriction, sodium restriction, increased consumption of vegetables, using low-fat dairy products) are recommended in patients with diabetes and hypertension.

I

A

It is recommended to initiate treatment with a combination of an RAS inhibitor and a CCB or thiazide/thiazide-like diuretic.

I

A

Pression Artérielle

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for lipids and diabetes		
Lipid targets in patients with diabetes		
In patients with T2DM at moderate CV risk, an LDL-C target of <2.6 mmol/L (<100 mg/dL) is recommended.	I	A
In patients with T2DM at high CV risk, an LDL-C target of <1.8 mmol/L (<70 mg/dL) and LDL-C reduction of at least 50% is recommended.	I	A
In patients with T2DM at very high CV risk, an LDL-C target of <1.4 mmol/L (<55 mg/dL) and LDL-C reduction of at least 50% is recommended.	I	B
In patients with T2DM, a secondary goal of a non-HDL-C target of <2.2 mmol/L (<85 mg/dL) in very high CV risk patients, and <2.6 mmol/L (<100 mg/dL) in high CV risk patients, is recommended.	I	B
Lipid-lowering treatment in patients with diabetes		
Statins are recommended as the first-choice LDL-C-lowering treatment in patients with diabetes and above-target LDL-C levels.	I	A
Administration of statins is defined based on the CV risk profile of the patients and the recommended LDL-C (or non-HDL-C) target levels.		
A PCSK9 inhibitor is recommended in patients at very high CV risk, with persistently high LDL-C levels above target despite treatment with a maximum tolerated statin dose, in combination with ezetimibe, or in patients with statin intolerance.	I	A
If the target LDL-C is not reached with statins, combination therapy with ezetimibe is recommended.	I	B

Lipides

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"What do to" and "what to not do" messages from the Guidelines

Recommendations for antithrombotic therapy in patients with diabetes and acute or chronic coronary syndrome without indications for long-term oral anticoagulation

ASA at a dose of 75–100 mg o.d. is recommended in patients with diabetes and previous MI or revascularization (CABG or stenting).	I	A
In patients with ACS and diabetes who undergo PCI, a P2Y ₁₂ receptor inhibitor (ticagrelor or prasugrel) is recommended in addition to ASA (75–100 mg o.d.), maintained over 12 months.	I	A
Clopidogrel 75 mg o.d. following appropriate loading (e.g. 600 mg or at least 5 days already on maintenance therapy) is recommended in addition to ASA for 6 months following coronary stenting in patients with CCS, irrespective of stent type, unless a shorter duration is indicated due to the risk or occurrence of life-threatening bleeding.	I	A
Clopidogrel is recommended as an alternative in case of ASA intolerance.	I	B
In patients with diabetes and ACS treated with DAPT who are undergoing CABG and do not require long-term OAC therapy, resuming a P2Y ₁₂ receptor inhibitor as soon as deemed safe after surgery and continuing it up to 12 months is recommended.	I	C

Recommendations for antithrombotic therapy in patients with diabetes and acute or chronic coronary syndrome and/or post-percutaneous coronary intervention requiring long-term oral anticoagulation

In patients with AF and receiving antiplatelet therapy, eligible for anticoagulation, and without a contraindication, NOACs are recommended in preference to a VKA.	I	A
In patients with ACS or CCS and diabetes undergoing coronary stent implantation and having an indication for anticoagulation, triple therapy with low-dose ASA, clopidogrel, and an OAC is recommended for at least 1 week, followed by dual therapy with an OAC and a single, oral, antiplatelet agent.	I	A

Recommendations for gastric protection

When antithrombotic drugs are used in combination, proton pump inhibitors are recommended to prevent gastrointestinal bleeding.	I	A
When clopidogrel is used, omeprazole and esomeprazole are not recommended for gastric protection.	III	B

Coronaropathies et Antithrombotiques

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"What do to" and "what to not do" messages from the Guidelines

Recommendations for revascularization in patients with diabetes

It is recommended that similar revascularization techniques are implemented (e.g. the use of DES and the radial approach for PCI, and the use of the left internal mammary artery as the graft for CABG) in patients with and without diabetes.

I

A

Myocardial revascularization in CCS is recommended when angina persists despite treatment with anti-anginal drugs or in patients with a documented large area of ischaemia (>10% LV).

I

A

Complete revascularization is recommended in patients with STEMI without cardiogenic shock and with multivessel CAD.

I

A

Routine immediate revascularization of non-culprit lesions in patients with MI with multivessel disease presenting with cardiogenic shock is not recommended.

III

B

Recommendations for glycaemic control in patients with diabetes and acute coronary syndrome

It is recommended to assess glycaemic status at initial evaluation in all patients with ACS.

I

B

It is recommended to frequently monitor blood glucose levels in patients with known diabetes or hyperglycaemia (defined as glucose levels ≥ 11.1 mmol/L or ≥ 200 mg/dL).

I

C

Coronaropathies : revascularisation

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for heart failure screening and diagnosis in patients with diabetes		
Evaluation for heart failure		
If HF is suspected, it is recommended to measure BNP/NT-proBNP.	I	B
Systematic survey for HF symptoms and/or signs of HF is recommended at each clinical encounter in all patients with diabetes.	I	C
Diagnostic tests in all patients with suspected heart failure		
12-lead ECG is recommended.	I	C
Transthoracic echocardiography is recommended.	I	C
Chest radiography (X-ray) is recommended.	I	C
Routine blood tests for comorbidities are recommended, including full blood count, urea, creatinine and electrolytes, thyroid function, lipids, and iron status (ferritin and TSAT).	I	C
Recommendations for heart failure treatments in patients with heart failure with reduced ejection fraction and diabetes		
Recommendations for pharmacological treatment indicated in patients with HFrEF (NYHA class II–IV) and diabetes		
SGLT2 inhibitors (dapagliflozin, empagliflozin, or sotagliflozin) are recommended in all patients with HFrEF and T2DM to reduce the risk of HF hospitalization and death.	I	A
Sacubitril/valsartan or an ACE-I is recommended in all patients with HFrEF and diabetes to reduce the risk of HF hospitalization and death.	I	A
Beta-blockers are recommended in patients with HFrEF and diabetes to reduce the risk of HF hospitalization and death.	I	A
MRAs are recommended in patients with HFrEF and diabetes to reduce the risk of HF hospitalization and death.	I	A
An intensive strategy of early initiation of evidence-based treatment (SGLT2 inhibitors, ARNI/ACE-Is, beta-blockers, and MRAs), with rapid up-titration to trial-defined target doses starting before discharge and with frequent follow-up visits in the first 6 weeks following a HF hospitalization is recommended to reduce re-admissions or mortality.	I	B

Insuffisance Cardiaque - 1

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for other treatments indicated in selected patients with HFrEF (NYHA class II-IV) and diabetes		
Device therapy with an ICD, CRT-P, or CRT-D is recommended in patients with diabetes, as in the general population with HFrEF.	I	A
ARBs are recommended in symptomatic patients with HFrEF and diabetes who do not tolerate sacubitril/valsartan or ACE-Is, to reduce the risk of HF hospitalization and death.	I	A
Diuretics are recommended in patients with HFrEF and diabetes with signs and/or symptoms of fluid congestion to improve symptoms, exercise capacity, and HF hospitalization.	I	C
Recommendations for the treatment of heart failure patients with left ventricular ejection fraction >40% and diabetes		
Empagliflozin or dapagliflozin are recommended in patients with T2DM and LVEF >40% (HFmrEF and HFpEF) to reduce the risk of HF hospitalization or CV death.	I	A
Diuretics are recommended in patients with HFpEF or HFmrEF and diabetes with signs and/or symptoms of fluid congestion to improve symptoms, exercise capacity, and HF hospitalization.	I	C

Insuffisance Cardiaque - 2

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for glucose-lowering medications in patients with type 2 diabetes with and without heart failure		
Recommendations for glucose-lowering medications to reduce heart failure hospitalization in patients with type 2 diabetes with or without existing heart failure		
SGLT2 inhibitors (empagliflozin, canagliflozin, dapagliflozin, ertugliflozin, or sotagliflozin) are recommended in patients with T2DM with multiple ASCVD risk factors or established ASCVD to reduce the risk of HF hospitalization.	I	A
SGLT2 inhibitors (dapagliflozin, empagliflozin, or sotagliflozin) are recommended in patients with T2DM and HFrEF to reduce the risk of HF hospitalization and death.	I	A
Empagliflozin or dapagliflozin are recommended in patients with T2DM and LVEF >40% (HFmrEF and HFpEF) to reduce the risk of HF hospitalization or CV death.	I	A
Recommendations for glucose-lowering medications with an increased risk of heart failure hospitalization in patients with type 2 diabetes		
Pioglitazone is associated with an increased risk of incident HF in patients with diabetes and is not recommended for glucose-lowering treatment in patients at risk of HF (or with previous HF).	III	A
The DPP-4 inhibitor saxagliptin is associated with an increased risk of HF hospitalization in patients with diabetes and is not recommended for glucose-lowering treatment in patients at risk of HF (or with previous HF).	III	B
Recommendations for special consideration in patients with heart failure and diabetes		
It is recommended to switch glucose-lowering treatment from agents without proven CV benefit or proven safety to agents with proven CV benefit.	I	C

Insuffisance Cardiaque - 3 - Traitements hypoglycémiants

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for atrial fibrillation in patients with diabetes

Screening for atrial fibrillation in diabetes

Opportunistic screening for AF by pulse taking or ECG is recommended in patients ≥ 65 years of age.

I

B

Opportunistic screening for AF by pulse taking or ECG is recommended in patients with diabetes < 65 years of age (particularly when other risk factors are present) because patients with diabetes exhibit a higher AF frequency at a younger age.

I

C

Anticoagulation for atrial fibrillation in patients with diabetes

Oral anticoagulation is recommended for preventing stroke in patients with AF and diabetes and with at least one additional (CHA₂DS₂-VASc) risk factor for stroke.

I

A

For preventing stroke in AF, NOACs are recommended in preference to VKAs, with the exception of patients with mechanical valve prostheses or moderate to severe mitral stenosis.

I

A

Fibrillation Atriale

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for patients with chronic kidney disease and diabetes		
Intensive LDL-C lowering with statins or a statin/ezetimibe combination is recommended.	I	A
A BP target of $\leq 130/80$ mmHg is recommended to reduce risk of CVD and albuminuria.	I	A
Personalized HbA1c targets 6.5–8.0% (48–64 mmol/mol) are recommended, with a target $<7.0\%$ (<53 mmol/mol) to reduce microvascular complications, wherever possible.	I	A
The maximum tolerated dose of an ACE-I or ARB is recommended.	I	A
A SGLT2 inhibitor (canagliflozin, empagliflozin, or dapagliflozin) is recommended in patients with T2DM and CKD with an eGFR ≥ 20 mL/min/1.73 m ² to reduce the risk of CVD and kidney failure.	I	A
Finerenone is recommended in addition to an ACE-I or ARB in patients with T2DM and eGFR >60 mL/min/1.73 m ² with a UACR ≥ 30 mg/mmol (≥ 300 mg/g), or eGFR 25–60 mL/min/1.73 m ² and UACR ≥ 3 mg/mmol (≥ 30 mg/g) to reduce CV events and kidney failure.	I	A
A GLP-1 RA is recommended at eGFR >15 mL/min/1.73 m ² to achieve adequate glycaemic control, due to low risk of hypoglycaemia and beneficial effects on weight, CV risk, and albuminuria.	I	A
Low-dose ASA (75–100 mg o.d.) is recommended in patients with CKD and ASCVD.	I	A
It is recommended that patients with diabetes are routinely screened for kidney disease by assessing eGFR defined by CKD-EPI and UACR.	I	B
Treatment with intensive medical or an initial invasive strategy is recommended in people with CKD, diabetes, and stable moderate or severe CAD, due to similar outcomes.	I	B
Combined use of an ARB with an ACE-I is not recommended.	III	B

Insuffisance rénale

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for aortic and peripheral arterial diseases and diabetes		
Lower-extremity artery disease in patients with diabetes		
In patients with diabetes and symptomatic LEAD, antiplatelet therapy is recommended.	I	A
In patients with diabetes and CLTI, it is recommended to assess the risk of amputation; the Wifl score is useful for this purpose.	I	B
As patients with diabetes and LEAD are at very high CV risk, an LDL-C target of <1.4 mmol/L (<55 mg/dL) and an LDL-C reduction of at least 50% is recommended.	I	B
Screening for LEAD is recommended on a regular basis, with clinical assessment and/or ABI measurement.	I	C
Patient education about foot care is recommended in patients with diabetes, and especially those with LEAD, even if asymptomatic. Early recognition of tissue loss and/or infection, and referral to a multidisciplinary team, is mandatory to improve limb salvage.	I	C
An ABI ≤ 0.90 is diagnostic of LEAD, irrespective of symptoms. In symptomatic cases, further assessment including duplex ultrasound is recommended.	I	C
When ABI is elevated (>1.40), other non-invasive tests, including TBI or duplex ultrasound, are recommended.	I	C
Duplex ultrasound is recommended as the first-line imaging method to assess the anatomy and haemodynamic status of lower-extremity arteries.	I	C
In case of CLTI, revascularization is recommended whenever feasible for limb salvage.	I	C
Carotid artery disease in patients with diabetes		
In patients with diabetes and carotid artery disease, it is recommended to implement the same diagnostic work-up and therapeutic strategies (medical, surgical, or endovascular) as in patients without diabetes.	I	C
Aortic aneurysm in patients with diabetes		
In patients with diabetes and aortic aneurysm, it is recommended to implement the same diagnostic work-up and therapeutic strategies (medical, surgical, or endovascular) as in patients without diabetes.	I	C

Artériopathies périphériques

Prise en Charge du Diabète - Recommandations ESC 2023

"What do to" and "what to not do" messages from the Guidelines

Recommendations for a multifactorial approach in patients with diabetes

Identifying and treating risk factors and comorbidities early is recommended.

I

A

A multifactorial approach to managing T2DM with treatment targets is recommended.

I

B

Multidisciplinary behavioural approaches that combine the knowledge and skills of different caregivers are recommended.

I

C

Recommendations for type 1 diabetes and cardiovascular disease

In patients with T1DM, it is recommended that adjustment of glucose-lowering medication follows principles of patient self-management under the guidance of the diabetes healthcare multidisciplinary team.

I

C

Avoiding hypoglycaemic episodes is recommended, particularly in those with established CVD.

I

C

Recommendations for person-centred care in diabetes

Structured education programmes are recommended in patients with diabetes to improve diabetes knowledge, glycaemic control, disease management, and patient empowerment.

I

A

Person-centred care is recommended to facilitate shared control and decision-making within the context of person priorities and goals.

I

C

Généralités et Diabète de Type 1

MERCI !

Pour votre attention

