# Cardiovascular Outcomes in Type 2 Diabetes – Updates to Treatment Approaches

## Page 2: Determine the need for EASD/ADA guideline updates

Q1. Following the publication of positive results for liraglutide in the LEADER trial and empagliflozin in the EMPA-REG OUTCOME trial, should current EASD/ADA guidelines be updated?

## Page 3: Please state how you believe EASD/ADA guidelines should be updated with regards to...

Q2. Patients with Type 2 Diabetes and established cardiovascular disease, at high risk of cardiovascular events**1 or more of: • history of myocardial infarction (MI)• evidence of multi-vessel coronary artery disease (CAD, significant stenosis or previous revascularisation)• evidence of single-vessel CAD plus positive non-invasive stress test for ischaemia or hospital discharge for unstable angina in past 12 months• unstable angina with presence of single- or multi-vessel CAD• history of stroke• occlusive peripheral artery disease

| | Recommendation | Supporting comments |
|---|---|---|
| **Assessment** | - | - |
| **Diagnosis** | - | - |
| **Management** | | - |
| **Monitoring** | - | - |
| **Evaluation of response to treatment** | - | - |
| **Other** | - | - |

## Page 4: Please state how you believe EASD/ADA guidelines should be updated with regards to...

Q3. Patients with Type 2 Diabetes and no established cardiovascular disease

| | Recommendation | Supporting comments |
|---|---|---|
| **Assessment** | | - |
| **Diagnosis** | - | - |
| **Management** | | - |
| **Monitoring** | - | - |
| **Evaluation of response to treatment** | - | - |
| **Other** | - | - |

## Page 5: Please state how you believe EASD/ADA guidelines should be updated with regards to...

Q4. Patients with Type 2 Diabetes and established renal disease* *eGFR (MDRD) <60 mL/min/1.73 m2 and/or macroalbuminuria (urine albumin-to-creatinine ratio >300 mg/g

*No Response*

## Page 6: Please state how you believe EASD/ADA guidelines should be updated with regards to...

Q5. Patients with Type 2 Diabetes and established renal* and cardiovascular disease***eGFR (MDRD) 300 mg/g**1 or more of: • history of myocardial infarction (MI)• evidence of multi-vessel coronary artery disease (CAD, significant stenosis or previous revascularisation)• evidence of single-vessel CAD plus positive non-invasive stress test for ischaemia or hospital discharge for unstable angina in past 12 months• unstable angina with presence of single- or multi-vessel CAD• history of stroke• occlusive peripheral artery disease

| | Recommendation | Supporting comments |
|---|---|---|
| **Assessment** | - | - |
| **Diagnosis** | - | - |
| **Management** | | - |
| **Monitoring** | - | - |
| **Evaluation of response to treatment** | - | - |
| **Other** | - | - |

## Page 7: Inter-professional, multidisciplinary team-based care

Q6. Please indicate how to improve long-term adherence rates and self-management in patients with Type 2 Diabetes and either cardiovascular or renal comorbidity.

*No Response*

Q7. Please indicate (and develop on how these integrate if needed) which specialties should be included to develop inter-professional, multidisciplinary team-based care for a comprehensive multifactorial risk-reduction strategy in the context of cardiovascular comorbidity.

**Diabetologist/Endocrinologist**

**Internist**

**Nephrologist** -

**Nutritionist/Dietician** -

Q7. Please indicate (and develop on how these integrate if needed) which specialties should be included to develop inter-professional, multidisciplinary team-based care for a comprehensive multifactorial risk-reduction strategy in the context of cardiovascular comorbidity.

| | |
|---|---|
| **Pharmacist** | - |
| **Nurses** | - |
| **Certified diabetes educator (incl. smoking cessation)** | - |

Q8. Please indicate (and develop on how these integrate if needed) which specialties should be included to develop inter-professional, multidisciplinary team-based care for a comprehensive multifactorial risk-reduction strategy in the context of renal comorbidity.

*No Response*