

SGLT2 INHIBITION SPOTLIGHT



BEST PRACTICES FORUM

MONDAY, FEBRUARY 22, 2021
8:00 – 9:30 PM EST

Practical Applications and Practice Implementation Worksheet

The patient with high risk diabetes

1. On your T2DM vascular risk reduction checklist, in addition to standard medications to consider (statins, ACE/ARB, ASA), include SGLT2i and GLP1RA on this list. Consider whether these medications are appropriate for each patient with T2DM that you see. Rather than thinking of SGLT2i and GLP1RA as diabetes medications that reduce vascular risk, think of them as vascular risk reducing medications that also improve glycemia.
2. SGLT2i and GLP1RA are appropriate to consider in high risk patients with T2DM, even if A1C is at target.
3. When starting an SGLT2i, consider whether insulin or SU needs to be reduced to avoid hypoglycemia, and whether adjustments in other BP lowering meds and/or diuretics need to be made.
4. Remember that it is not a competition between SGLT2i and GLP1RA - these two important vascular risk reducing classes of medications can both be utilized in many patients.

What are your next steps to implement this learning into your practice?

Are any patients in your practice coming to mind that you feel you need to follow up with?

The patient with chronic kidney disease

1. Diabetic Kidney Disease (DKD) patients have “malignant” CV Risk
2. CV Risk reduction in DKD is paramount
3. SGLT2i have wide reach for ASCVD/CHF and DKD (Unlike GLP1-RA)
4. Diabetes Canada recommends SGLT2i for most people with DKD
5. Placebo like tolerability

Cautions:

1. Active ischemic/PAD/gangrene
2. Diuretic adjustment if low BP or Volume contraction.
3. Sick Day Medication Advice (e.g. gastroenteritis, vomiting, diarrhea...)
4. SGLT2i are NOT nephrotoxic



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The patient with heart failure

1. All patients with symptomatic HFrEF should be ideally treated with a beta-blocker, aldosterone antagonist (spironolactone), sacubitril/valsartan (instead of an ACEi or ARB alone), and an SGLT2 inhibitor. Each of these agents independently improves morbidity and mortality in HFrEF patients. The selection of specific agents should be based on evidence from clinical trials and doses titrated to guideline recommended dosing.
2. In elderly/frail patients, or those with borderline renal function, who are euvolemic, consider reducing the dose of furosemide by 50% when adding an SGLT2i for heart failure.
3. SGLT2 inhibitors should be considered for all symptomatic HFrEF patients regardless of whether they have diabetes or not.

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Are any patients in your practice coming to mind that you feel you need to follow up with?

We hope you enjoyed this CCRN Best Practices Forum!

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