ABORDAJE DEL TRATAMIENTO INTENSIVO PRECOZ en **DM2**

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Duality of Interest

- KK: Received funds for research, acted as consultant to or received honoraria from Boehringer Ingelheim, Lilly, MSD, Novartis, Novo Nordisk, Roche, Sanofi-Aventis, Takeda and Unilever.
- XC: Ha recibido honorarios ensayos clínicos, cunsultant y advisory board Boehringer Ingelheim, Lilly, MSD, Abbott, Novartis, Novo Nordisk, Sanofi-Aventis y Astra-Zeneca.

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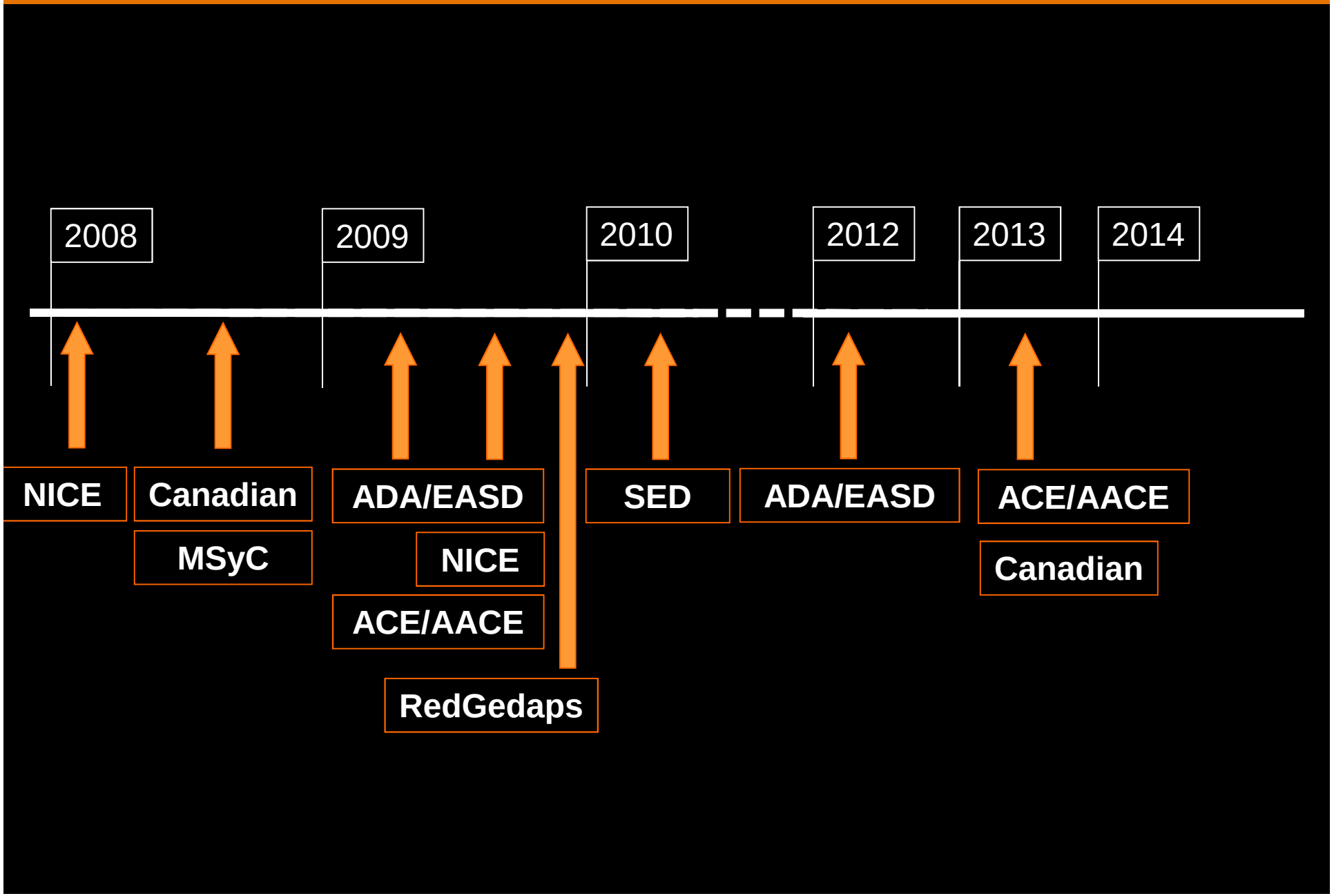
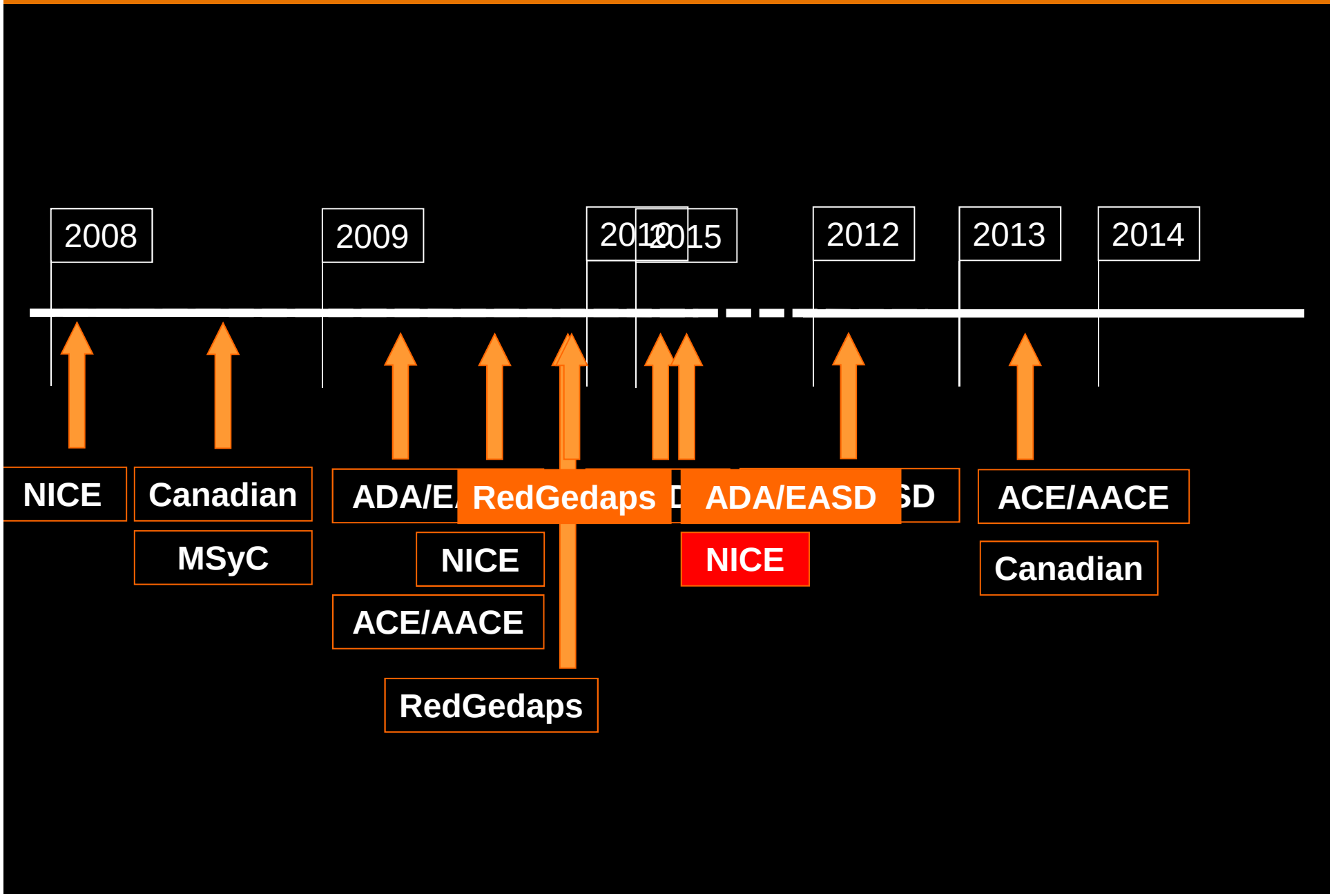
- Guias/recomendaciones Tto. Diabetes
- “La vida real”
- Complejidad de la individualización
- Tratamiento intensivo precoz
- Take-home messages

Guias-Recomendaciones

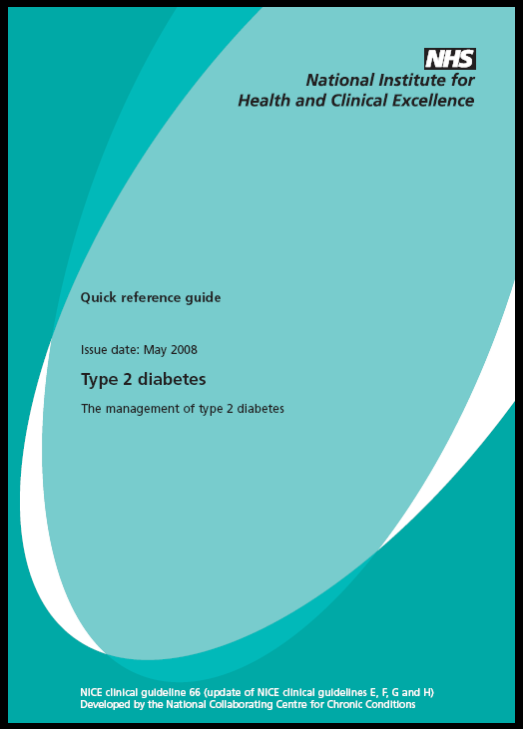


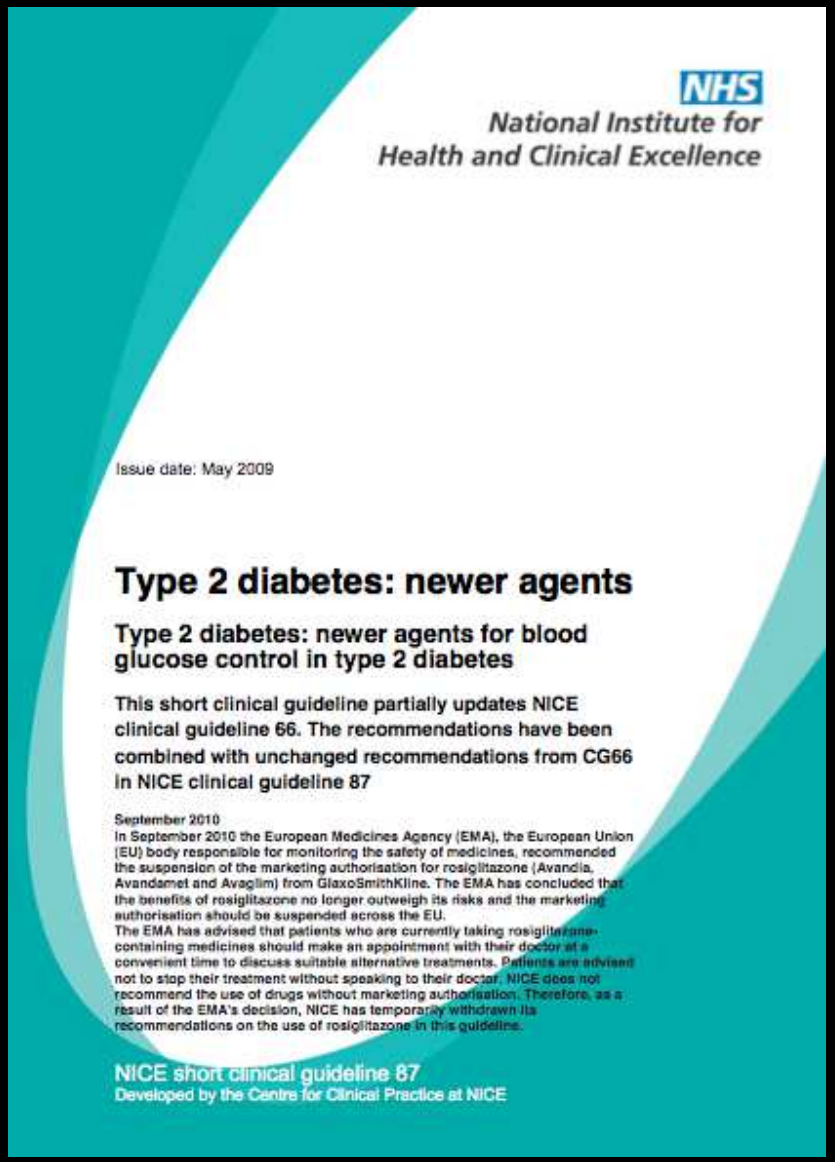
Guias-Recomendaciones



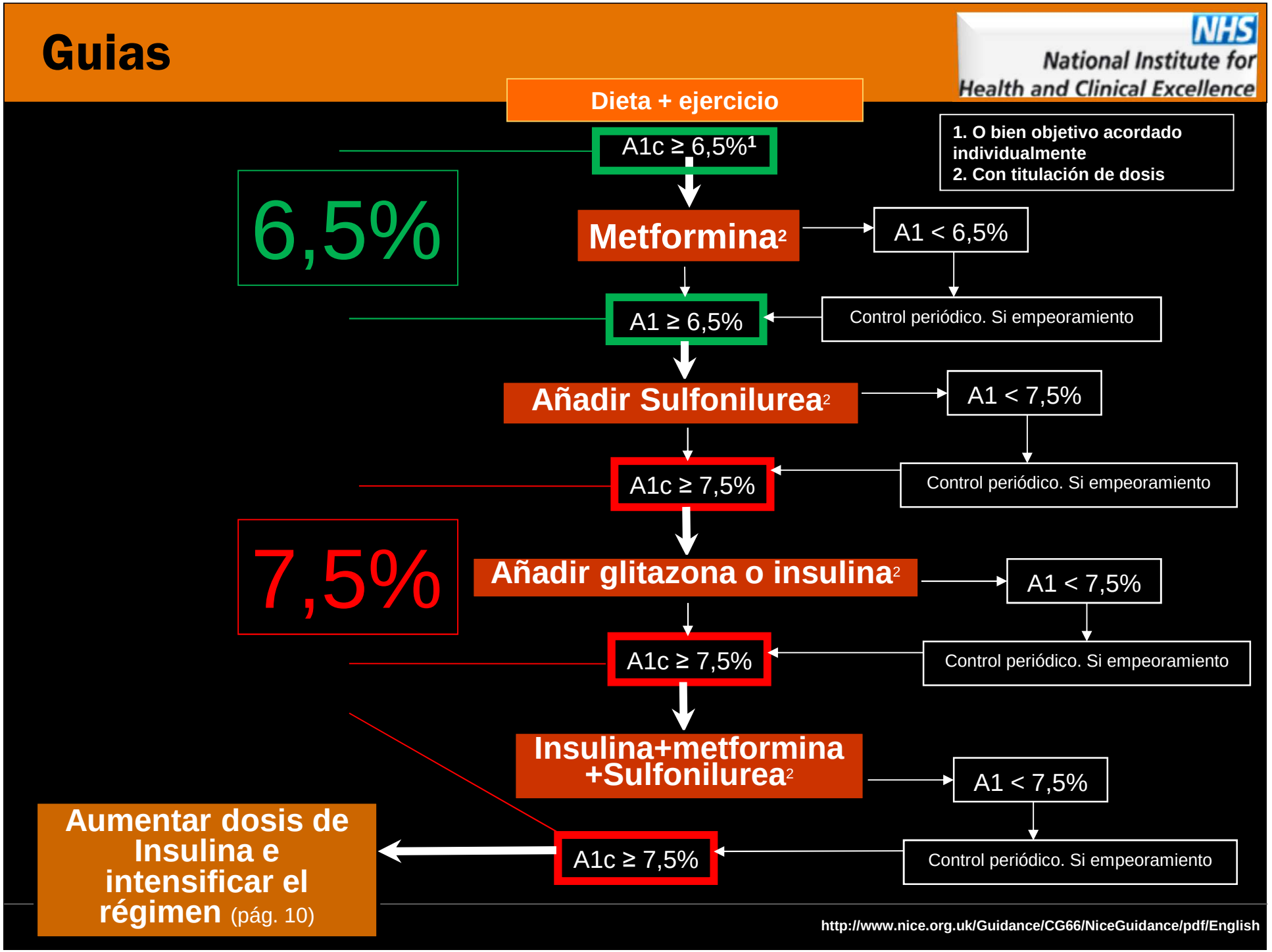
Guias-Recomendaciones

NHS
National Institute for
Health and Clinical Excellence

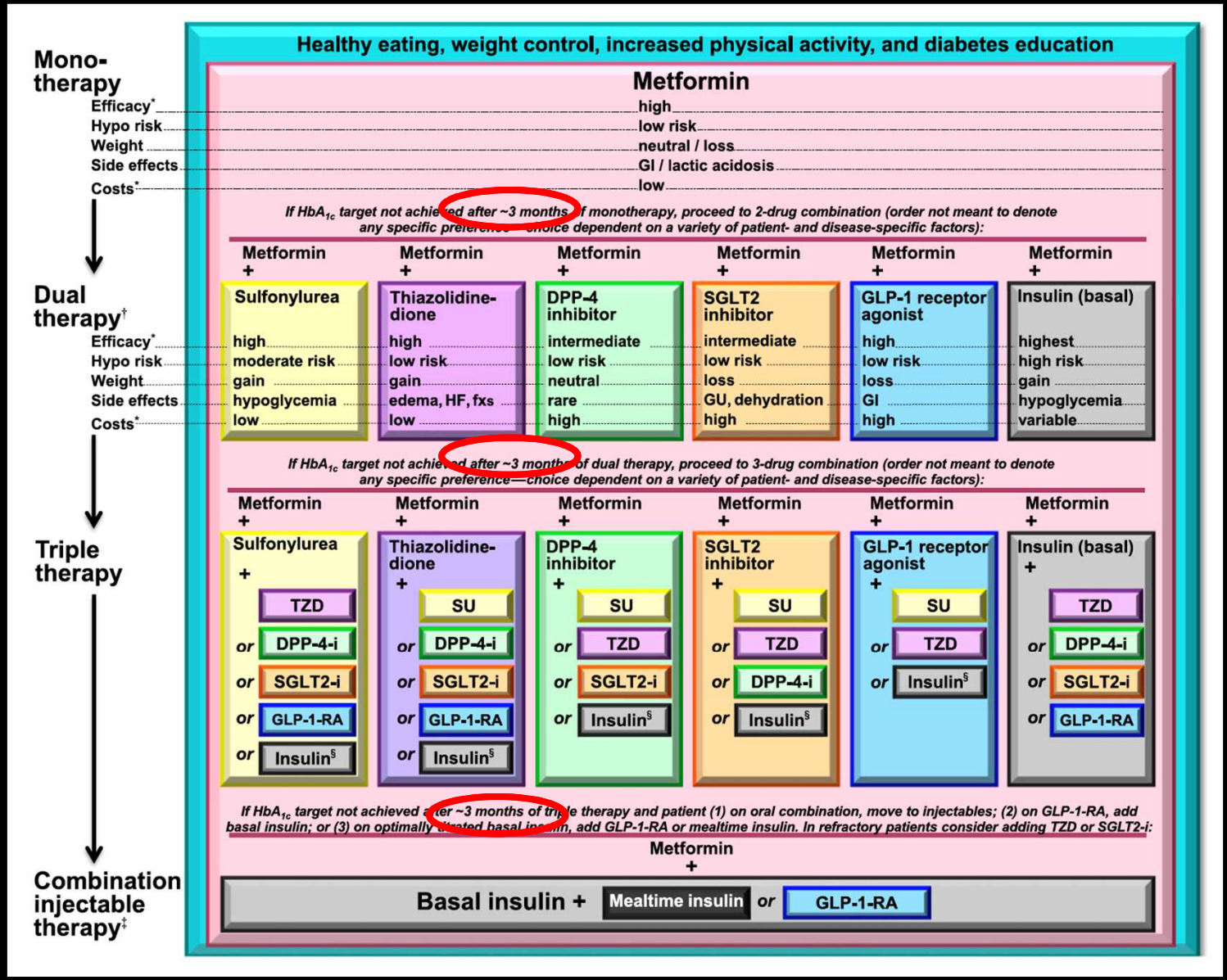




Guias

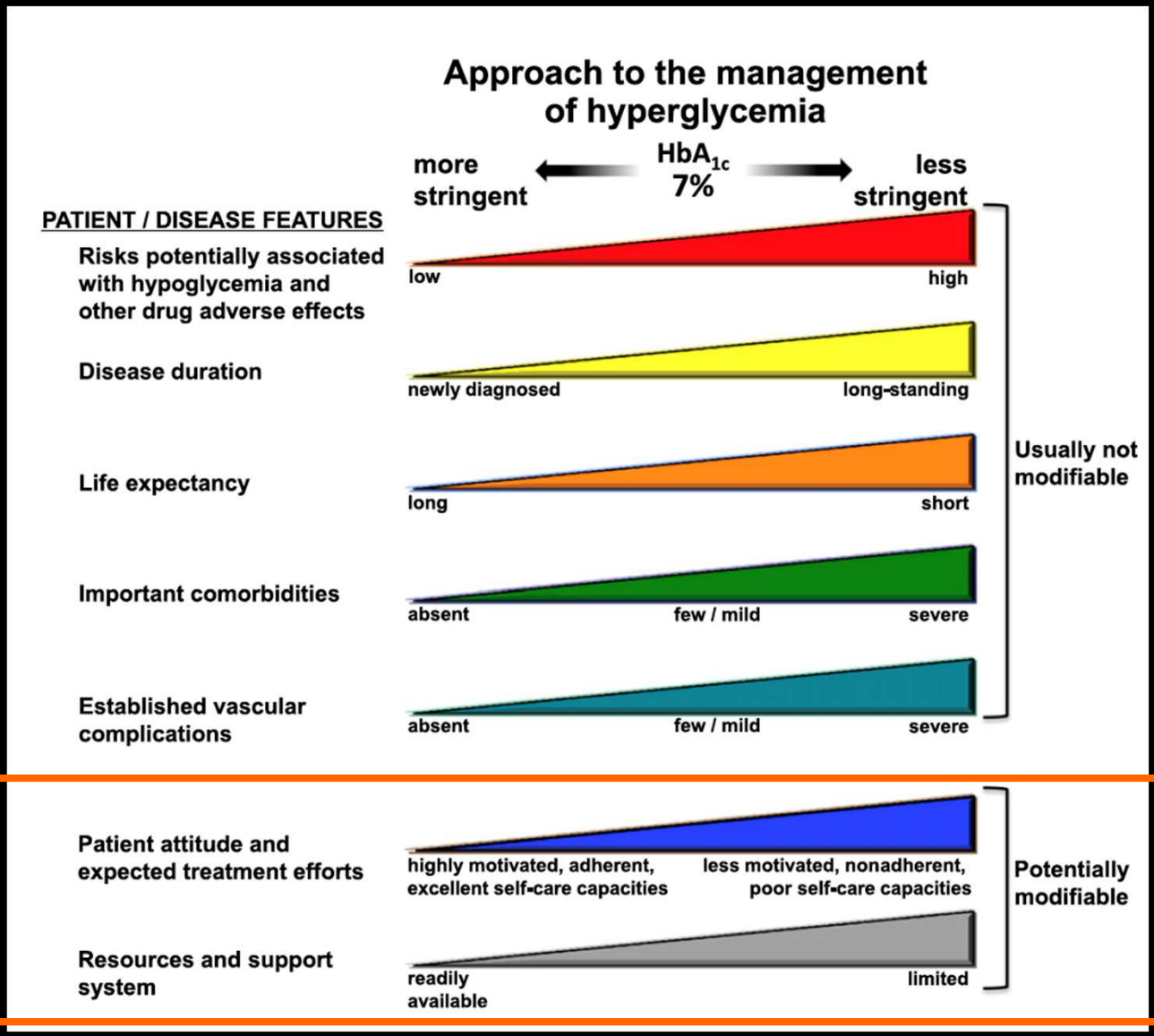

NHS
National Institute for Health and Clinical Excellence
Dieta + ejercicio
A1c ≥ 6,5%1
1. O bien objetivo acordado individualmente
2. Con titulación de dosis
6,5%
Metformina2
A1 < 6,5%
A1 ≥ 6,5%
Control periódico. Si empeoramiento
Añadir Sulfonilurea2
A1 < 7,5%
A1c ≥ 7,5%
Control periódico. Si empeoramiento
7,5%
Añadir glitazona o insulina2
A1 < 7,5%
A1c ≥ 7,5%
Control periódico. Si empeoramiento
Insulina+metformina +Sulfonilurea2
A1 < 7,5%
A1c ≥ 7,5%
Control periódico. Si empeoramiento
Aumentar dosis de Insulina e intensificar el régimen (pág. 10)
http://www.nice.org.uk/Guidance/CG66/NiceGuidance/pdf/English

Guias-Recomendaciones



Management of Hyperglycemia in Type 2 Diabetes, 2015: A Patient-Centered Approach: Update to a Position Statement of the American Diabetes Association and the European Association for the Study of Diabetes. Diabetes Care. 2015 Jan;38(1):140-149.

Guias-Recomendaciones



Based on an original figure by Ismail-Beigi et al.

Management of Hyperglycemia in Type 2 Diabetes, 2015: A Patient-Centered Approach: Update to a Position Statement of the American Diabetes Association and the European Association for the Study of Diabetes. Diabetes Care. 2015 Jan;38(1):140-149.

Canadian Diabetes Association Clinical Practice Guidelines

Pharmacologic Management of Type 2 Diabetes

Chapter 13

William Harper, Maureen Clement, Ronald Goldenberg, Amir Hanna, Andrea Main, Ravi Retnakaran, Diana Sherifali,Vincent Woo, Jean-François Yale

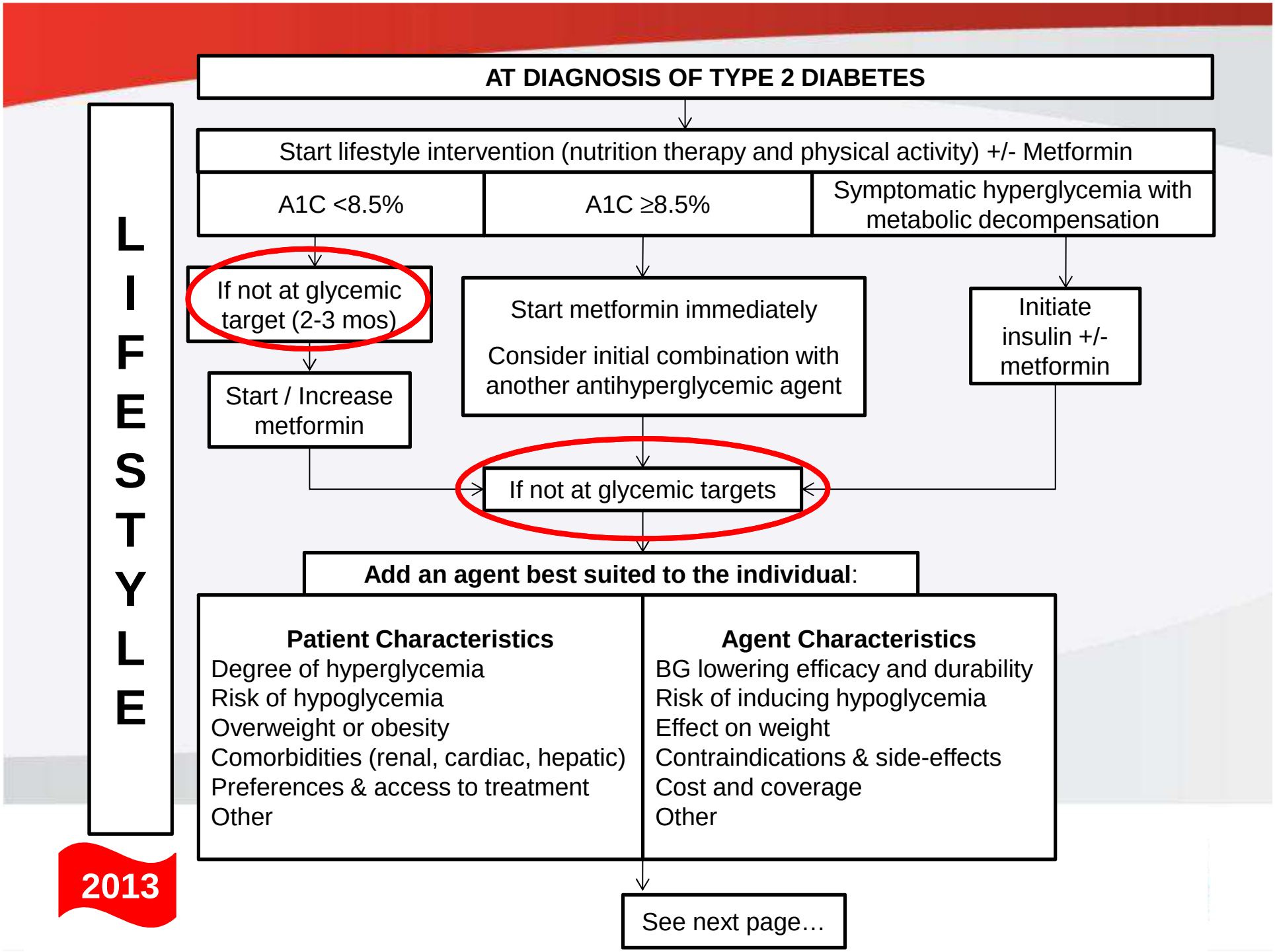
Clinical Practice Guidelines

Pharmacologic Management of Type 2 Diabetes

Canadian Diabetes Association Clinical Practice Guidelines Expert Committee

The initial draft of this chapter was prepared by William Harper MD, FRCPC, Maureen Clement MD, CCFP, Ronald Goldenberg MD, FRCPC, FACE, Amir Hanna MB, BCh, FRCPC, FACP, Andrea Main BScPhm, CDE, Ravi Retnakaran MD, MSc, FRCPC, Diana Sherifali RN, PhD, CDE, Vincent Woo MD, FRCPC, Jean-François Yale MD, CSPQ, FRCPC

Canadian Diabetes Association


AT DIAGNOSIS OF TYPE 2 DIABETES
Start lifestyle intervention (nutrition therapy and physical activity) +/- Metformin
A1C <8.5%
A1C ≥8.5%
Symptomatic hyperglycemia with metabolic decompensation
If not at glycemic target (2-3 mos)
Start / Increase metformin
Start metformin immediately
Consider initial combination with another antihyperglycemic agent
Initiate insulin +/- metformin
If not at glycemic targets
Add an agent best suited to the individual:
Patient Characteristics
Degree of hyperglycemia
Risk of hypoglycemia
Overweight or obesity
Comorbidities (renal, cardiac, hepatic)
Preferences & access to treatment
Other
Agent Characteristics
BG lowering efficacy and durability
Risk of inducing hypoglycemia
Effect on weight
Contraindications & side-effects
Cost and coverage
Other
See next page…
LIFESTYLE
2013

From prior page…

LIFESTYLE

Add an agent best suited to the individual (agents listed in alphabetical order):

Class	Relative A1C lowering	Hypo-glycemia	Weight	Other therapeutic considerations	Cost
Alpha-glucosidase inhibitor (acarbose)	↓	Rare	neutral to ↓	Improved postprandial control, GI side effects	$$
Incretin agents: DPP-4 Inhibitors GLP-1 receptor agonists	 ↓↓ ↓↓ to ↓↓↓	 Rare Rare	 neutral to ↓ ↓↓	 GI side effects	 $$$ $$$$
Insulin	↓↓↓	Yes	↑↑	No dose ceiling, flexible regimens	$-$$$$
Insulin secretagogue: Meglitinide Sulfonylurea	 ↓↓ ↓↓	 Yes Yes	 ↑ ↑	 Less hypoglycemia in context of missed meals but usually requires TID to QID dosing Gliclazide and glimepiride associated with less hypoglycemia than glyburide	 $$ $
TZD	↓↓	Rare	↑↑	CHF, edema, fractures, rare bladder cancer (pioglitazone), cardiovascular controversy (rosiglitazone), 6-12 weeks required for maximal effect	$$
Weight loss agent (orlistat)	↓	None	↓	GI side effects	$$$

If not at glycemic target

- Add another agent from a different class
- Add/Intensify insulin regimen

Make timely adjustments to attain target A1C within 3-6 months

2013

Glycemic Control Algorithm

LIFESTYLE MODIFICATION
(Including Medically Assisted Weight Loss)

ENTRY A1c < 7.5%

MONOTHERAPY*
- Metformin
- GLP-1 RA
- DPP4-i
- AG-i
- SGLT-2 **
- TZD
- SU/GLN

If A1c > 6.5% in 3 months add second drug (Dual Therapy)

ENTRY A1c ≥ 7.5%

DUAL THERAPY*
- GLP-1 RA
- DPP4-i
- TZD
- ** SGLT-2
- Basal insulin
- Colesevelam
- Bromocriptine QR
- AG-i
- SU/GLN

MET + other first-line agent

If not at goal in 3 months proceed to triple therapy

TRIPLE THERAPY*
- GLP-1 RA
- TZD
- ** SGLT-2
- Basal insulin
- DPP4-i
- Colesevelam
- Bromocriptine QR
- AG-i
- SU/GLN

MET + 2ND LINE AGENT or other first-line agent

If not at goal in 3 months proceed to or intensify insulin therapy

ENTRY A1c > 9.0%

NO SYMPTOMS
- DUAL THERAPY
- OR
- TRIPLE THERAPY

SYMPTOMS
- INSULIN ± OTHER AGENTS

ADD OR INTENSIFY INSULIN

* Order of medications listed are a suggested hierarchy of usage

** Based upon phase 3 clinical trials data

LEGEND

✓ = Few adverse events or possible benefits

⚠ = Use with caution

PROGRESSION OF DISEASE

Guias

avances en Diabetología

Av Diabetol. 2010;26:331-8

Autores

E. Menéndez Torre[1], J. Lafita Tejedor[1], S. Artola Menéndez[1], J. Millán Núñez-Cortés[2], Á. Alonso García[3], M. Puig Domingo[4], J.R. García Solans[5], F. Álvarez Guisasola[6], J. García Alegría[7], J. Mediavilla Bravo[8], C. Miranda Fernández-Santos[9], R. Romero González[10]

[1]En representación del Grupo de Trabajo de Consensos y Guías Clínicas de la Sociedad Española de Diabetes. [2]Sociedad Española de Arteriosclerosis (SEA). [3]Sociedad Española de Cardiología (SEC). [4]Sociedad Española de Endocrinología y Nutrición (SEEN). [5]Sociedad Española de Farmacia Comunitaria (SEFAC). [6]Sociedad Española de Medicina Familiar y Comunitaria (SEMFYC). [7]Sociedad Española de Medicina Interna (SEMI). [8]Sociedad Española de Médicos de Atención Primaria

Documento de consenso

Recomendaciones para el tratamiento farmacológico de la hiperglucemia en la diabetes tipo 2

Recommendations for the pharmacologic treatment of hyperglycemia in type 2 diabetes

Aten Primaria. 2011 Apr;43(4):202.e1-202.e9. Epub 2011 Mar 5.

[Recommendations for the pharmacological treatment of hyperglycemia in type 2 diabetes.]

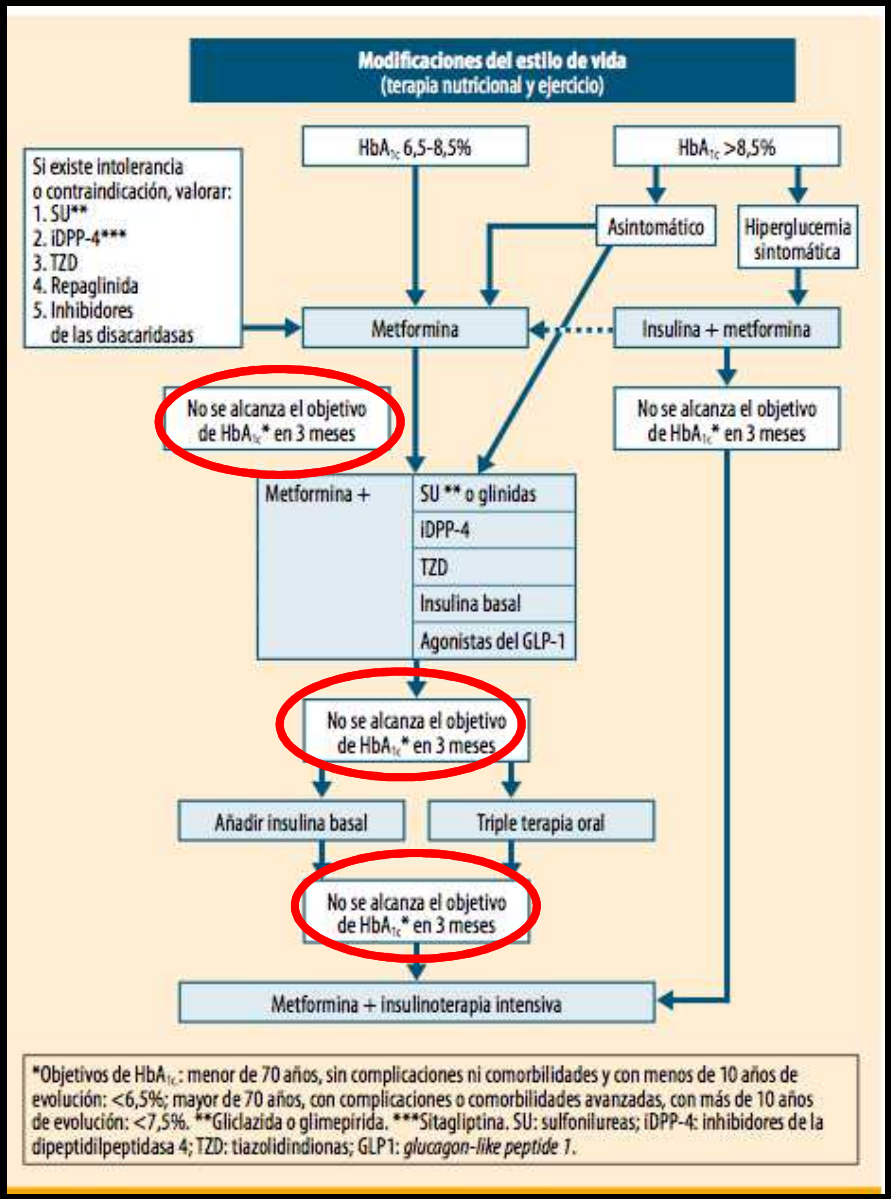
[Article in Spanish]

Menéndez Torre E, Lafita Tejedor FJ, Artola Menéndez S, Millán Núñez-Cortés J, Alonso García A, Puig Domingo M, García Solans JR,

En representación del Grupo de Trabajo de Consensos y Guías Clínicas de la Sociedad Española de Diabetes, España.

PMID: 21382648 [PubMed - as supplied by publisher] Free Article

Guias-Recomendaciones



Guias-Recomend

Dieta + ejercicio

A1c>7%

Metformina

A1c>7%

Añadir Sulfonilurea*
o glitazona, o glinida, o inhibidor DPP-4, o inhibidor α-

Criterios mayores de Insulinización

- Hiperglucemia severa
- Cetosis
- Pérdida de peso
- Embarazo

Nuevo Algoritmo RedGDPS 2014

Añadir insulina basal
o tercer fármaco oral o agonista GLP-1*

A1c>7%

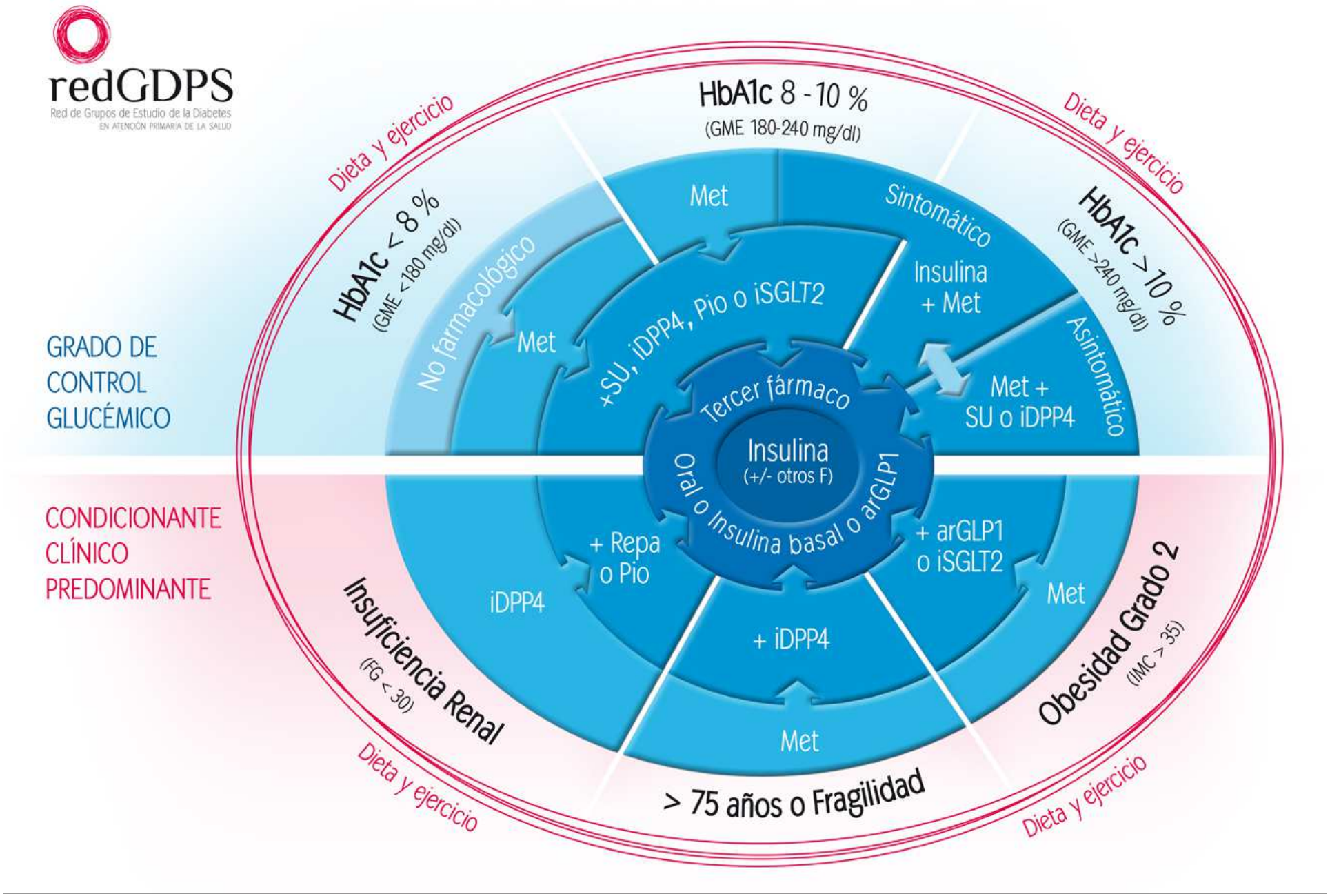
Insulina en monoterapia (dos o más inyecciones)

A1c>7%

Metformina + insulina (dos o más inyecciones)

El objetivo de A1c <7% (o <53 mmol/mol) se debe individualizar según las características del paciente.

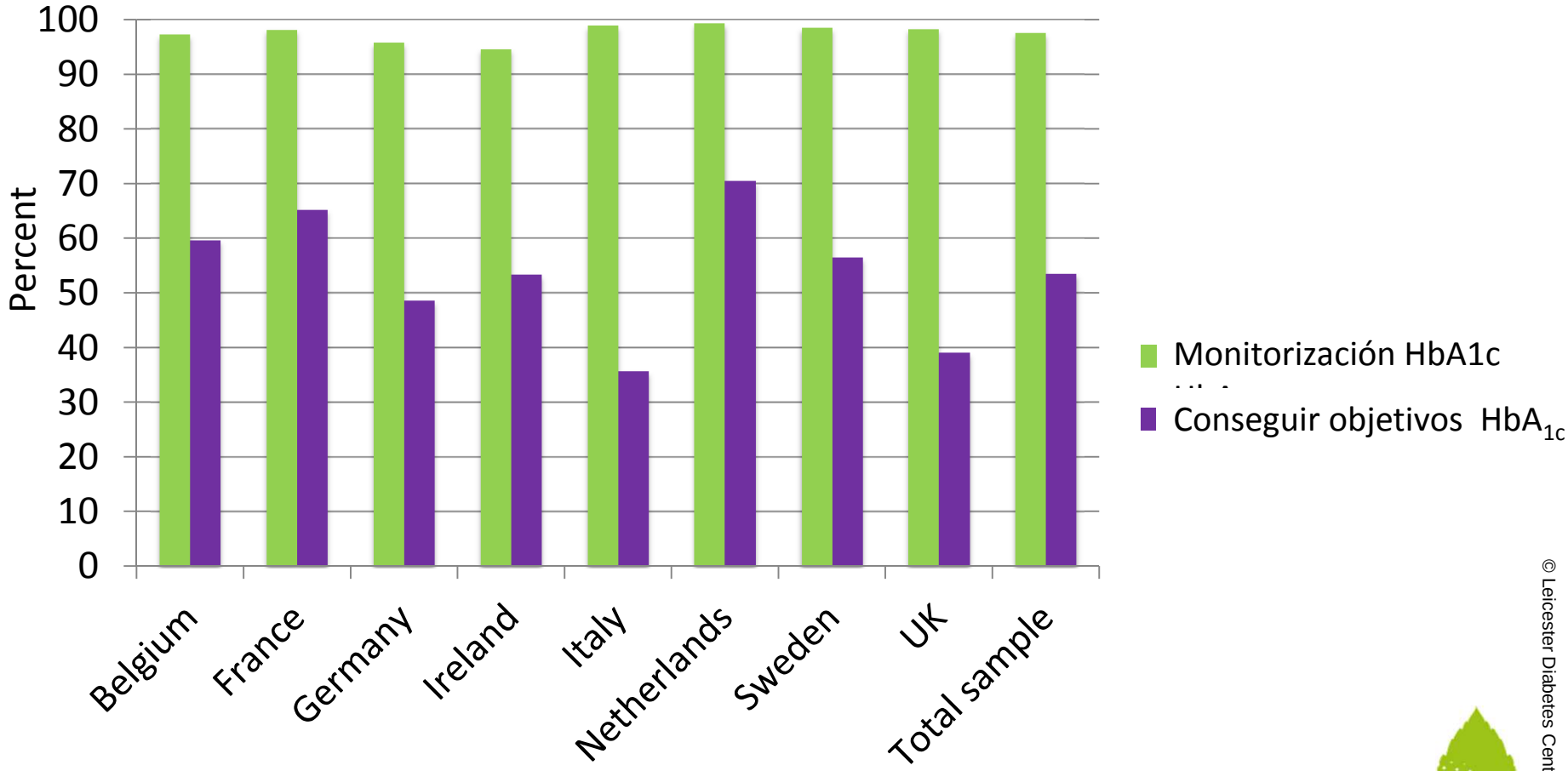
* El segundo o tercer fármaco oral se elegirá en función de las características del paciente y las ventajas e inconvenientes de cada fármaco. En algunos casos se puede optar por añadir insulina basal en el segundo escalón. Ocasionalmente, como alternativa a la insulinización, puede utilizarse un agonista de GLP1 en asociación con metformina y/o sulfonilurea si IMC>30 kg/m2 (35 según la guía NICE 2008)


redGDPS
Red de Grupos de Estudio de la Diabetes
EN ATENCIÓN PRIMARIA DE LA SALUD
GRADO DE CONTROL GLUCÉMICO
CONDICIONANTE CLÍNICO PREDOMINANTE
HbA1c 8 - 10 %
(GME 180-240 mg/dl)
HbA1c < 8 %
(GME <180 mg/dl)
HbA1c > 10 %
(GME >240 mg/dl)
Dieta y ejercicio
Dieta y ejercicio
Dieta y ejercicio
Dieta y ejercicio
Dieta y ejercicio
No farmacológico
Met
Met
+SU, iDPP4, Pio o iSGLT2
Sintomático
Insulina + Met
Asintomático
Met + SU o iDPP4
Tercer fármaco
Insulina
(+/- otros F)
Oral o Insulina basal o arGLP1
iDPP4
+ Repa o Pio
+ iDPP4
+ arGLP1 o iSGLT2
Met
Met
Insuficiencia Renal
(FG < 30)
> 75 años o Fragilidad
Obesidad Grado 2
(IMC > 35)

A pesar de los avances terapéuticos, una proporción significativa de pacientes DM2 no alcazan los objetivos de A1c

GUIDANCE Study 7,597 pacientes con T2DM

Existe un vacio entre monitorizacion y control de la HbA_{1c} <7%



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T2DM, type 2 diabetes mellitus.
Stone MA et al. *Diabetes Care*. 2013 April 23.

Control of Glycemia and Cardiovascular Risk Factors in Patients With Type 2 Diabetes in Primary Care in Catalonia (Spain)

Irene Vinagre, MD[1]
Manel Mata-Cases, MD[2,3]
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Bonaventura Bolíbar, MD, MPH[3,4]
Didac Mauricio, MD, PHD[8,9]

Many studies have shown that the occurrence of these complications depends largely on the degree of glycemic control and intensive control of cardiovascular risk factors (CVRFs) (3–5).

In the last few decades, a consensus

N 286.791 pacientes diabéticos

H 153.987 **M** 132.804
Edad 68.2
A1c 7.15 % (1.46)
Tiempo Dx 6.5 años
IMC 29.6 kg /m2 (5.0)
HTA 77.8 %

Vinagre et al. Diabetes Care 2012;35.

Control of Glycemia and Cardiovascular Risk Factors in Patients With Type 2 Diabetes in Primary Care in Catalonia (Spain)

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Many studies have shown that the occurrence of these complications depends largely on the degree of glycemic control and intensive control of cardiovascular risk factors (CVRFs) (3–5).

In the last few decades, a consensus

	Age <65 years	Age ≥65 years	Age <65 s	Age ≥65 years
A	women = 102,063; ≥65 years = 139,161)			58.5
A				82.5
A				3.3
B	A1C ≤7% (242,842; women = 114,493; ≥65 years = 159,838	51.8	58.5	30.9
B				61.9
T	A1C ≤8% ,623; women = 91,627; ≥65 years = 126,014)	74.2	82.5	63.4
L	A1C >10% 199,586; women = 95,426; ≥65 years = 130,529)	8	3.3	40.6
L				75.2
T				35.4
B	Secondary prevention: A1C ≤7%, BP ≤130/80 mmHg, and LDL-C <100 mg/dL (*n* = 34,310; women = 12,200; ≥65 years = 27,386)	11.9	12.1	42.1
N				73.7
Primary prevention: A1C ≤7%, BP ≤130/80 mmHg, and LDL-C <130 mg/dL (*n* = 145,605; women = 71,246; ≥65 years = 91,689)	12.9	13.3	12.7	12.2	13.3
Secondary prevention: A1C ≤7%, BP ≤130/80 mmHg, and LDL-C <100 mg/dL (*n* = 34,310; women = 12,200; ≥65 years = 27,386)	12.1	13.3	9.9	11.9	12.1

Dara are percentages. The primary and secondary prevention treatment goals were defined according to the local guidelines. The percentages are from the study subjects with available data for each variable. All variables showed significant differences between sex ($P < 0.005$) and age groups ($P < 0.001$).

Vinagre et al. Diabetes Care 2012;35.

Leicester Diabetes Centre

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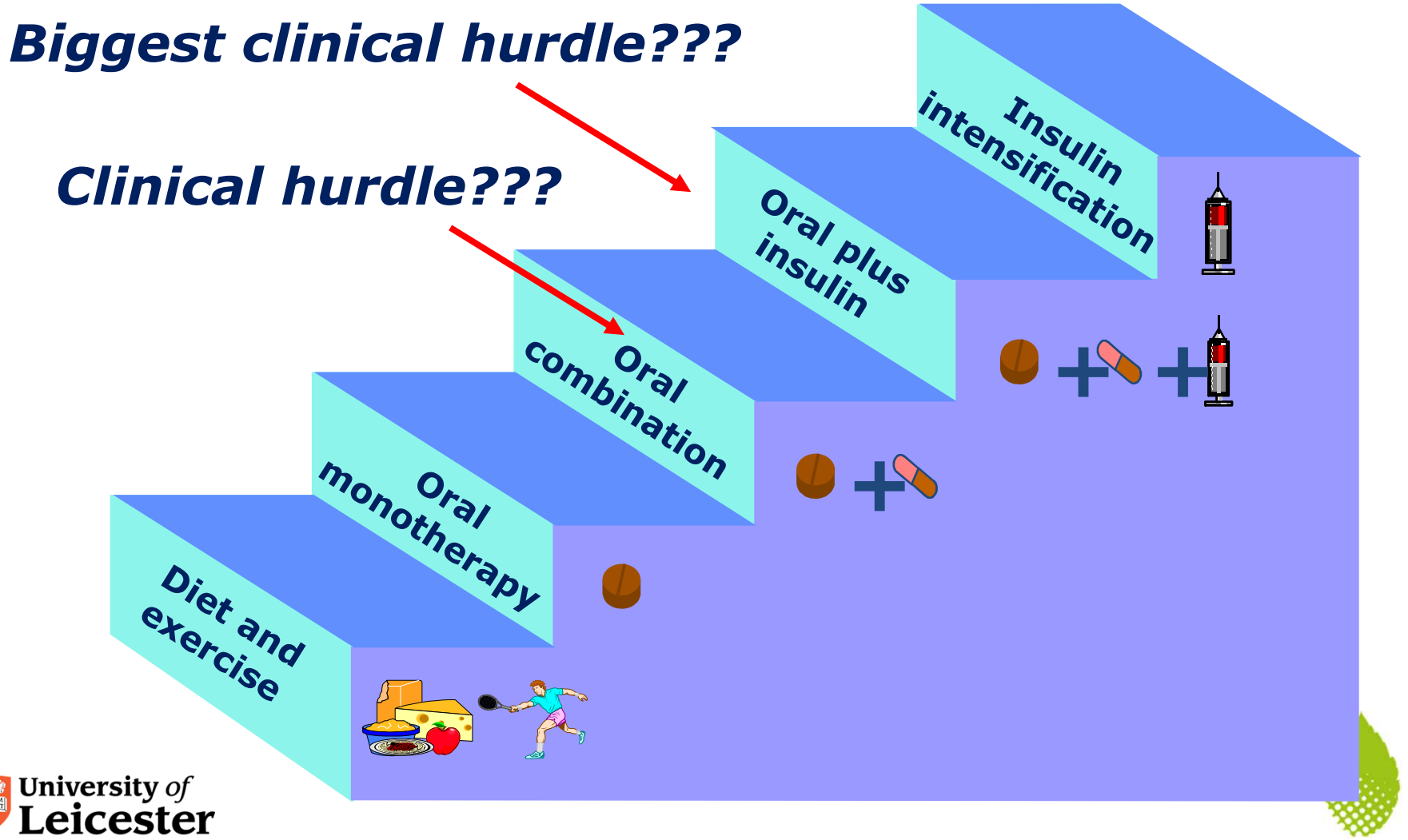
Stepwise management of type 2 diabetes



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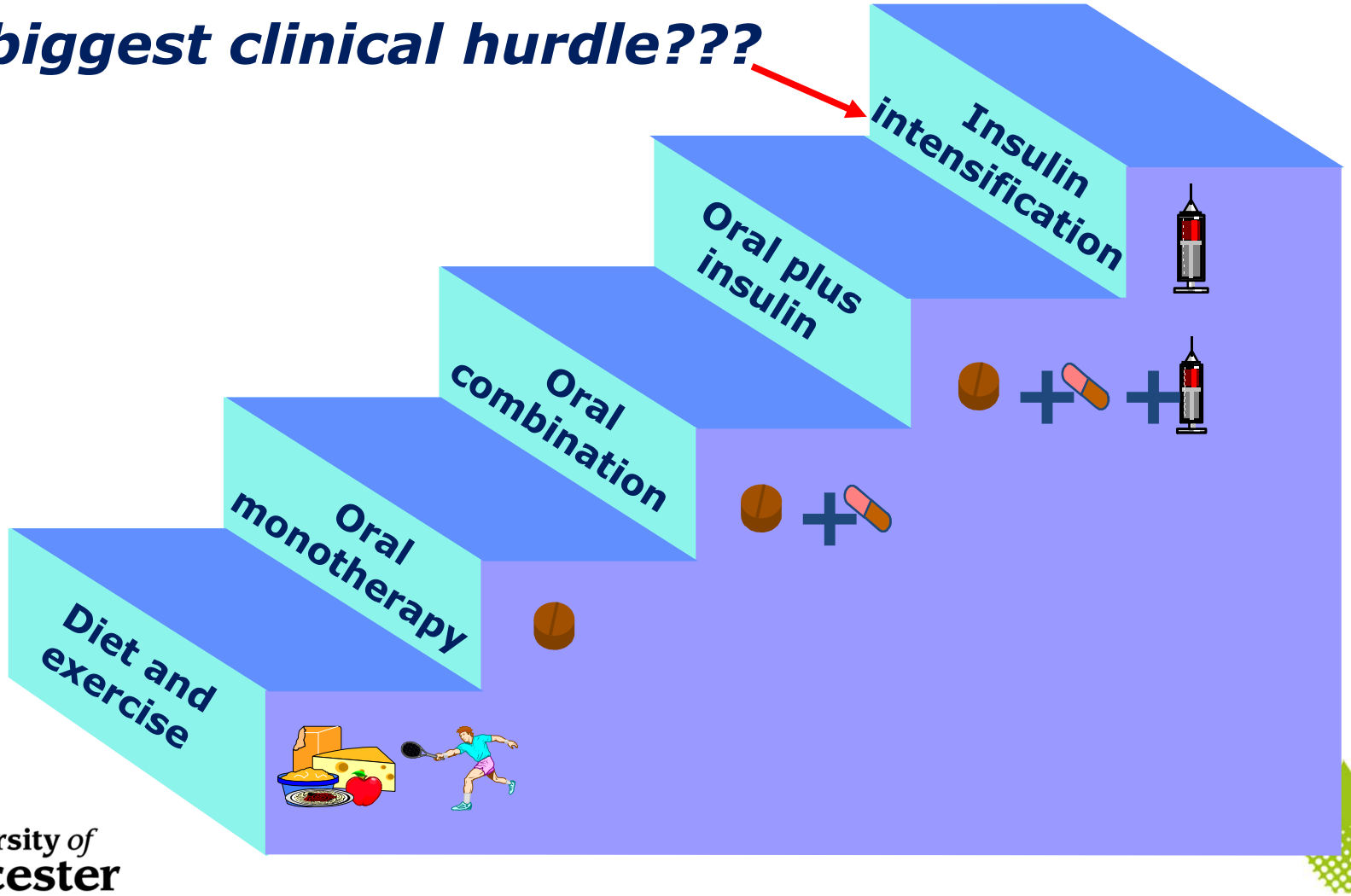
Stepwise management of type 2 diabetes

Or biggest clinical hurdle???



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What is clinical inertia?

"Failure to advance therapy when required"

- Insulin is often only initiated after years of poor glycaemic control
- Despite TTT trials demonstrating effectiveness and simplicity of adding insulin therapy to treatment regimens
- Multifaceted problem in clinical practice worldwide

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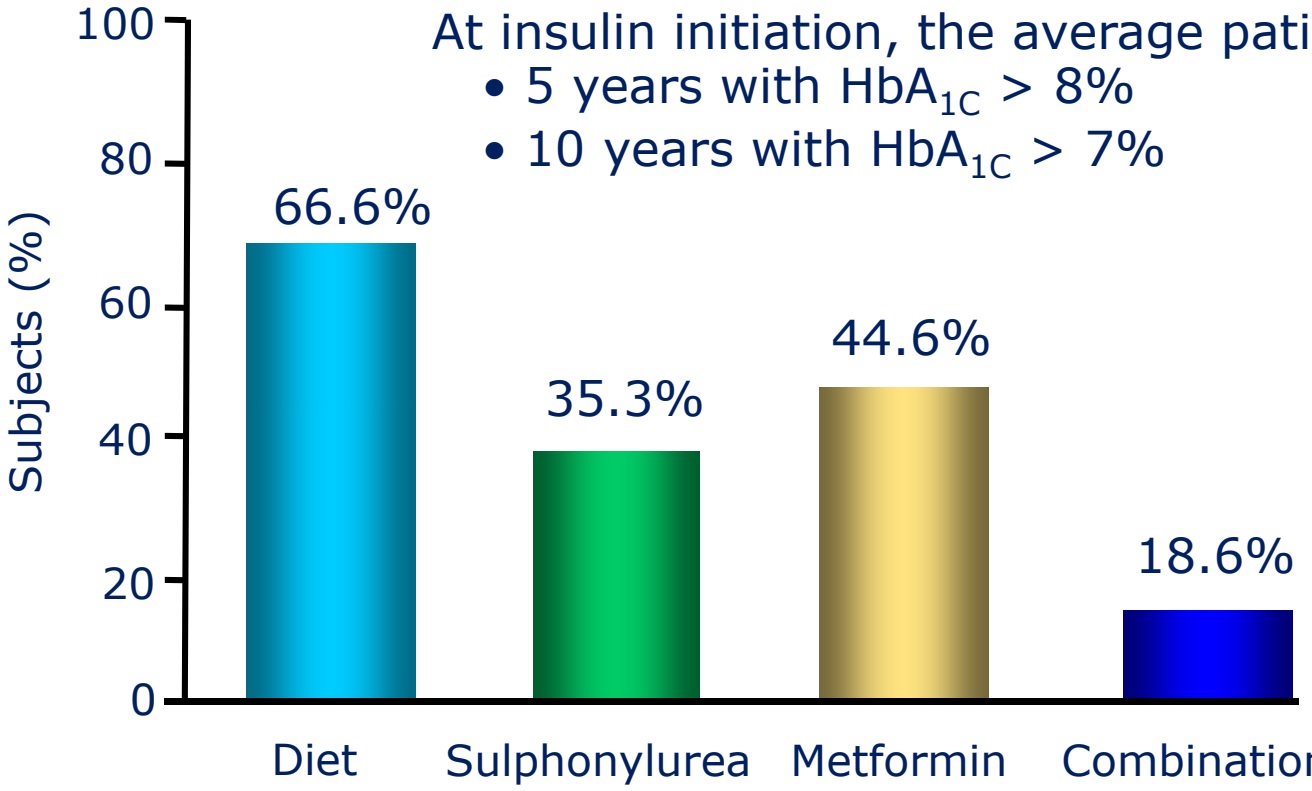
TTT, treat to target
Caputo *et al.* IDF abstract book 2011. P-1450

Clinical inertia: "Failure to advance therapy when required"

Percentage of subjects advancing when HbA_{1C} > 8%



At insulin initiation, the average patient had:

- 5 years with HbA_{1C} > 8%
- 10 years with HbA_{1C} > 7%

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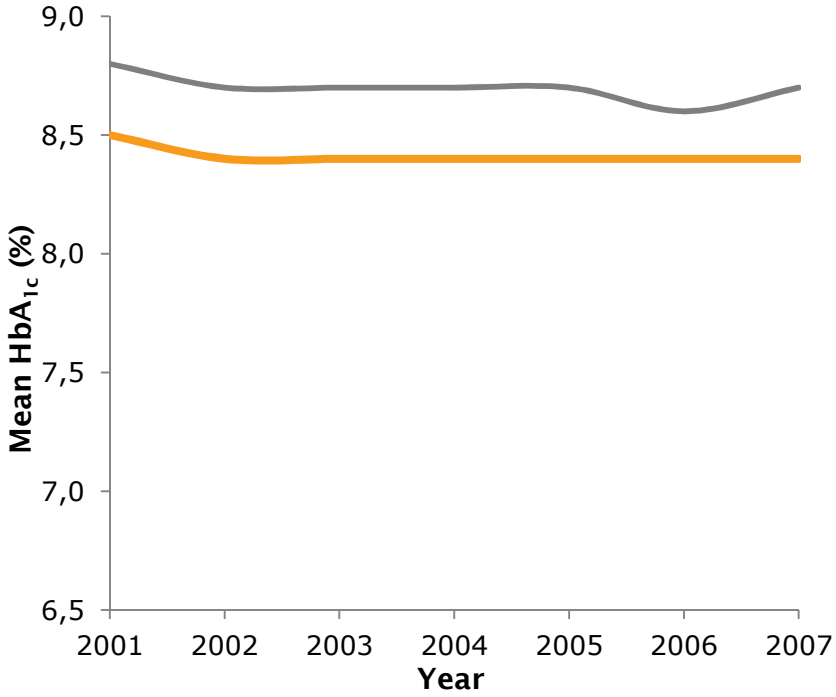
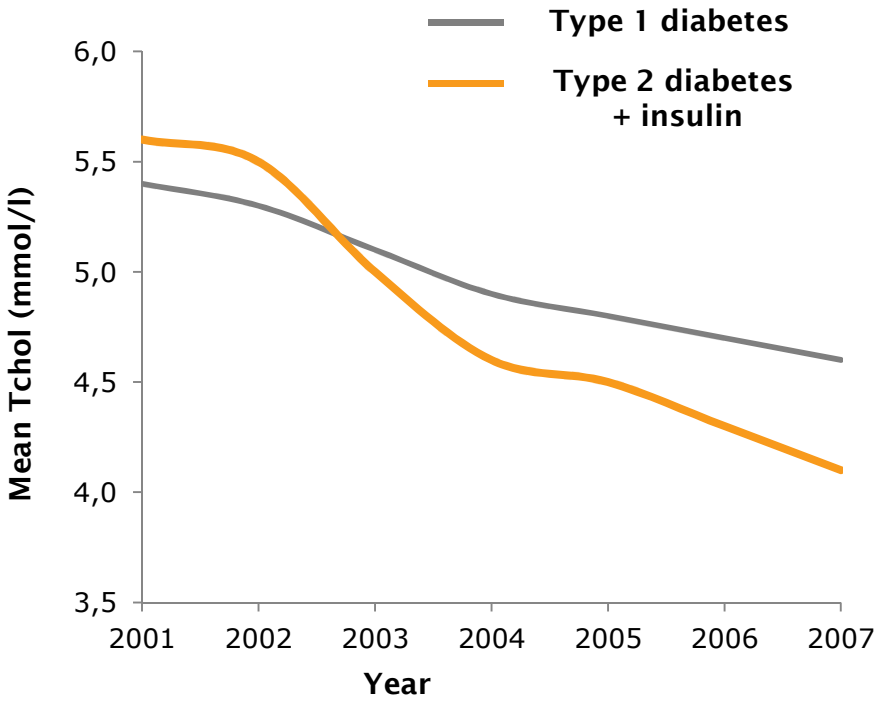
Brown *et al. Diabetes Care* 2004;27:1535–40

Challenges associated with achieving optimal glycaemic goals





In patients with type 1 diabetes or type 2 diabetes on insulin, there was a 0.1% relative improvement in HbA_{1c} vs. improvements in total cholesterol of 15% and 29%, respectively between 2001 and 2007

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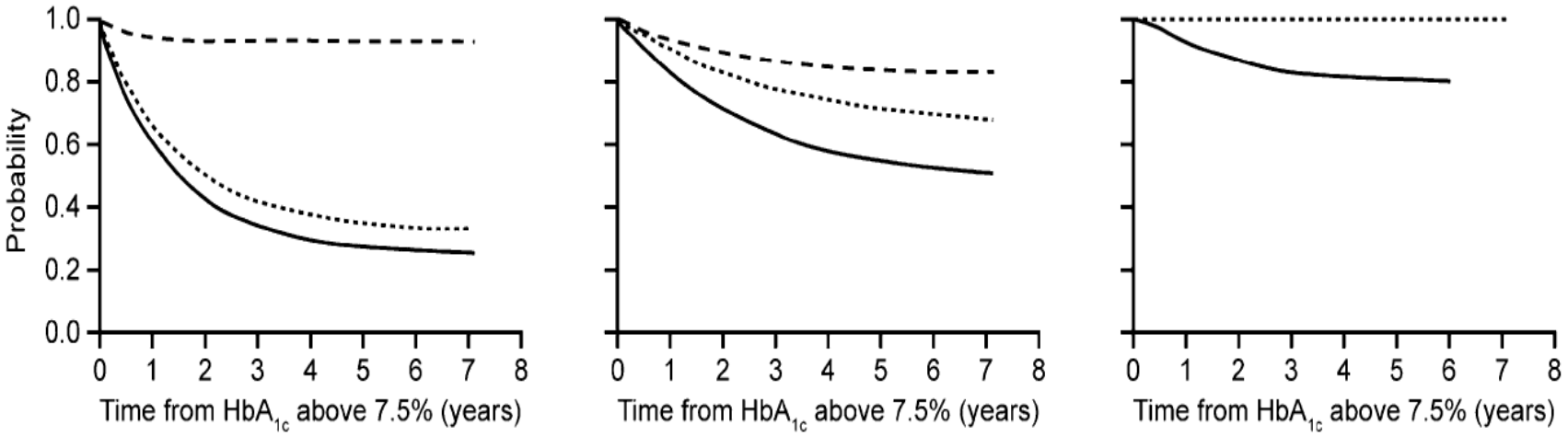
Currie et al. Diabetic Medicine 2010; 27:938-948

Clinical inertia in T2DM

- Retrospective cohort study of over 80,000 people
- Time to treatment intensification from first HbA1c above 7.5%, by number of OADs and type of intensification

Cut-off HbA1c 7.5% (58 mmol/mol)



Median: 1.5 years | Median: >7.2 years | Median: >6.1 years

*Proportion of people with HbA1c >7.5% having any intensification to their treatment at end of follow-up according to number of OADs

Khunti K, *et al. Diabetes Care* 1013;Epub ahead of print.

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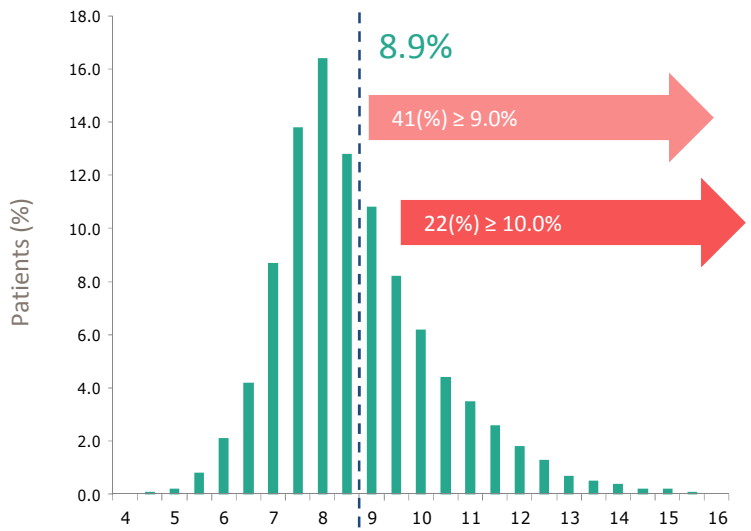
There is a need for earlier insulin initiation – baseline HbA_{1c}

Distribution of HbA_{1c} at time of insulin initiation



Clinical inertia exists despite:

- The benefits of timely glycaemic control
- Guidelines encouraging earlier use of insulin

At insulin initiation in SOLVE™:

The average HbA_{1c} was 8.9%

41% had $HbA_{1c} \geq 9.0\%$

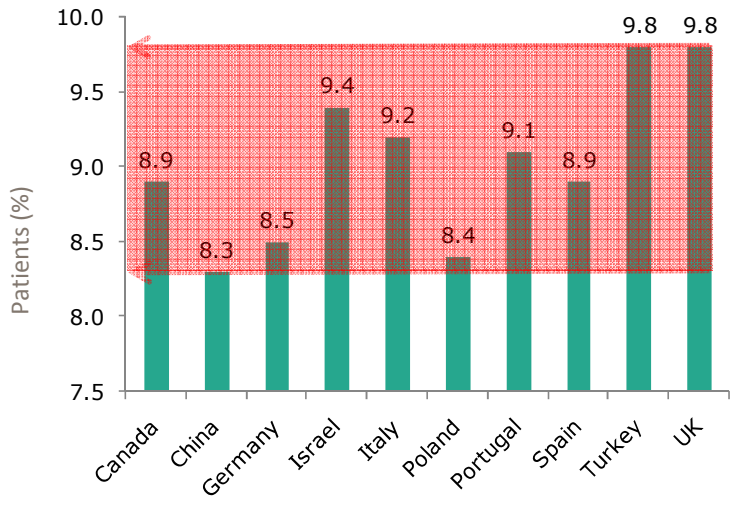
22% had $HbA_{1c} \geq 10.0\%$

Khunti *et al. Diab Obes Metabolism2012*

University of Leicester

There is a need for earlier insulin initiation – baseline HbA_{1c} (Countries)

Mean pre-insulin HbA_{1c} by country



Patients remain poorly controlled on OAD treatment for prolonged periods of time

At insulin initiation in SOLVE™, mean pre-insulin HbA_{1c} range was:

8.3% (China)

9.8% (Turkey/UK)

Khunti K et al. Diab Obeity Metabolism 2012

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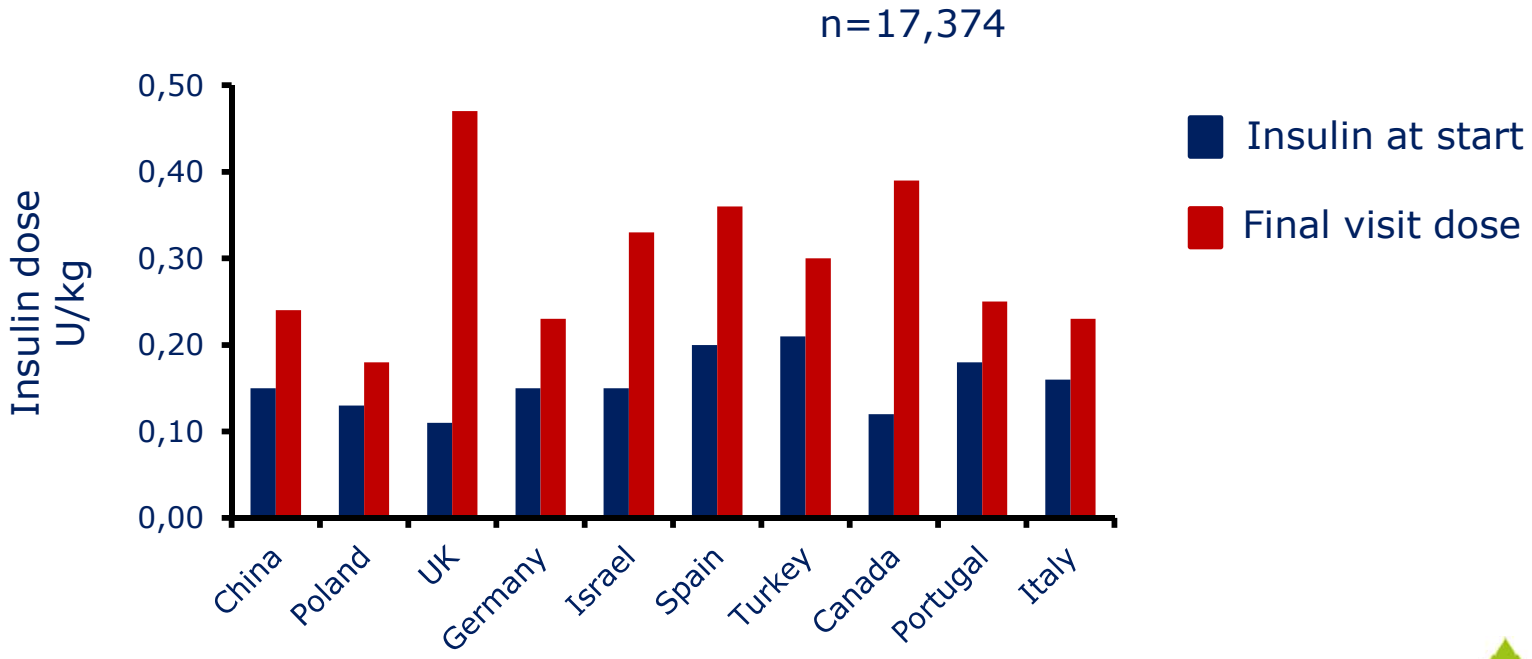
Clinical inertia in T2D in real-life clinical practice (at 24 weeks)



Khunti K et al. Diab Obeity Metabolism 2012

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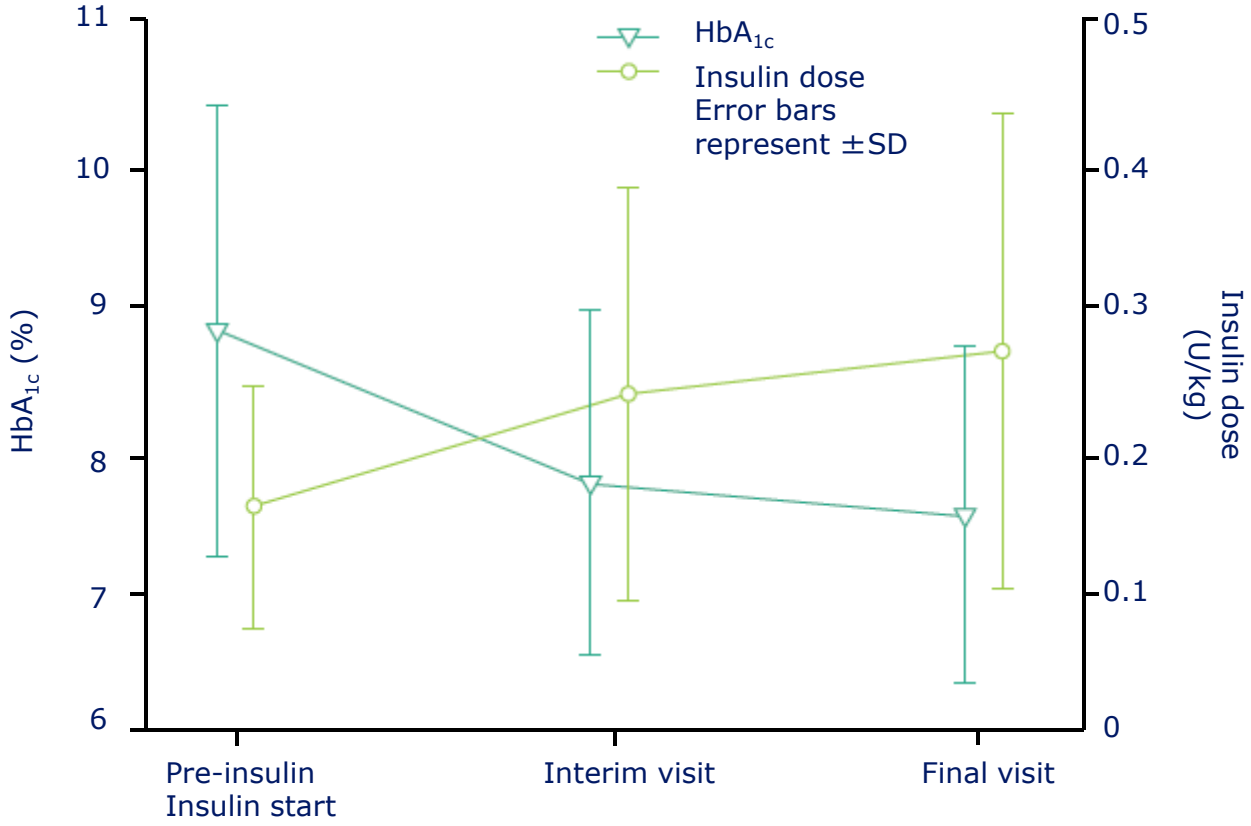
Mean HbA_{1c} and mean insulin dose in the total SOLVE™ cohort



Khunti K et al. Diab Obeity Metabolism 2012

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Clinical inertia and CV events

105477 newly diagnosed T2DM (11.3% previous CVD)
5.3 years median follow-up
6 month delay in first 2 years of treatment with HbA1c > 7.0%

	MI	Stroke	HF	Any CVE
All patients	1.38 (1.16-1.82)	1.07 (0.89-1.29)	1.28 (1.10-1.48)	1.25 (1.13-1.39)
No Previous CVD	1.21 (1.00-1.47)	1.07 (0.87-1.31)	1.28 (1.07-1.52)	1.20 (1.07-1.35)
Previous CVD	1.91 (1.40-2.60)	1.08 (0.73-1.61)	1.27 (0.95-1.70)	1.42 (1.15-1.75)

Values in table correspond to HR (95% CI)

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Paul S *et al.* Poster presented at EASD 2013.

Issues that underpin clinical inertia

- Multimorbidity
- Hypoglycaemia
- Complex regimens
- Data about perceived insulin outcomes
- Lack of patient adherence to treatment
- Lack of education
- Financial incentives

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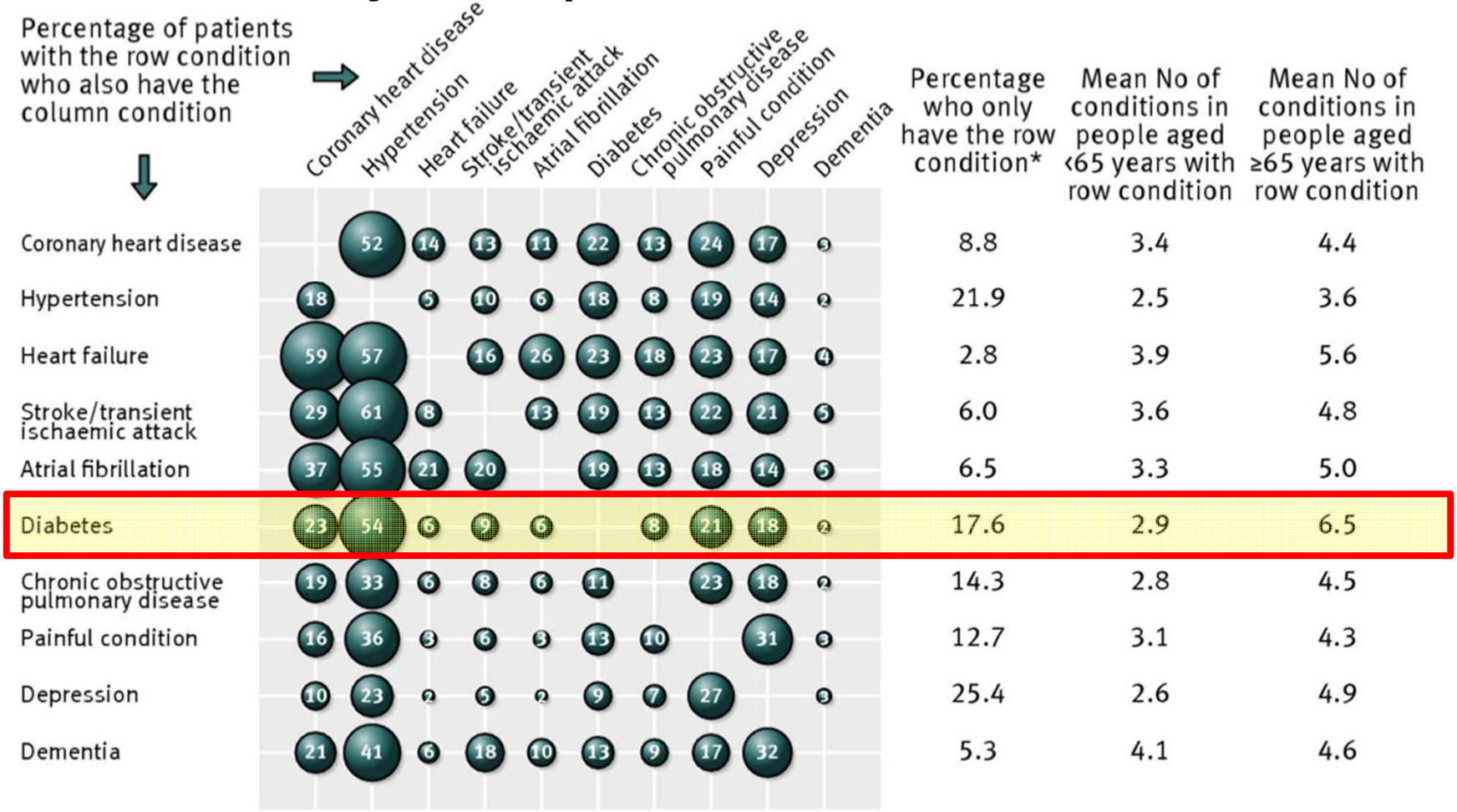
Comorbidity of top 10 common conditions



Percentage of patients with the row condition who also have the column condition

	Coronary heart disease	Hypertension	Heart failure	Stroke/transient ischaemic attack	Atrial fibrillation	Diabetes	Chronic obstructive pulmonary disease	Painful condition	Depression	Dementia	Percentage who only have the row condition*	Mean No of conditions in people aged <65 years with row condition	Mean No of conditions in people aged ≥65 years with row condition
Coronary heart disease		52	14	13	11	22	13	24	17	3	8.8	3.4	4.4
Hypertension	18		5	10	6	18	8	19	14	2	21.9	2.5	3.6
Heart failure	59	57		16	26	23	18	23	17	4	2.8	3.9	5.6
Stroke/transient ischaemic attack	29	61	8		13	19	13	22	21	5	6.0	3.6	4.8
Atrial fibrillation	37	55	21	20		19	13	18	14	5	6.5	3.3	5.0
Diabetes	23	54	6	9	6		8	21	18	2	17.6	2.9	6.5
Chronic obstructive pulmonary disease	19	33	6	8	6	11		23	18	2	14.3	2.8	4.5
Painful condition	16	36	3	6	3	13	10		31	3	12.7	3.1	4.3
Depression	10	23	2	5	2	9	7	27		3	25.4	2.6	4.9
Dementia	21	41	6	18	10	13	9	17	32		5.3	4.1	4.6

* Percentage who do not have one of 39 other conditions in the full count

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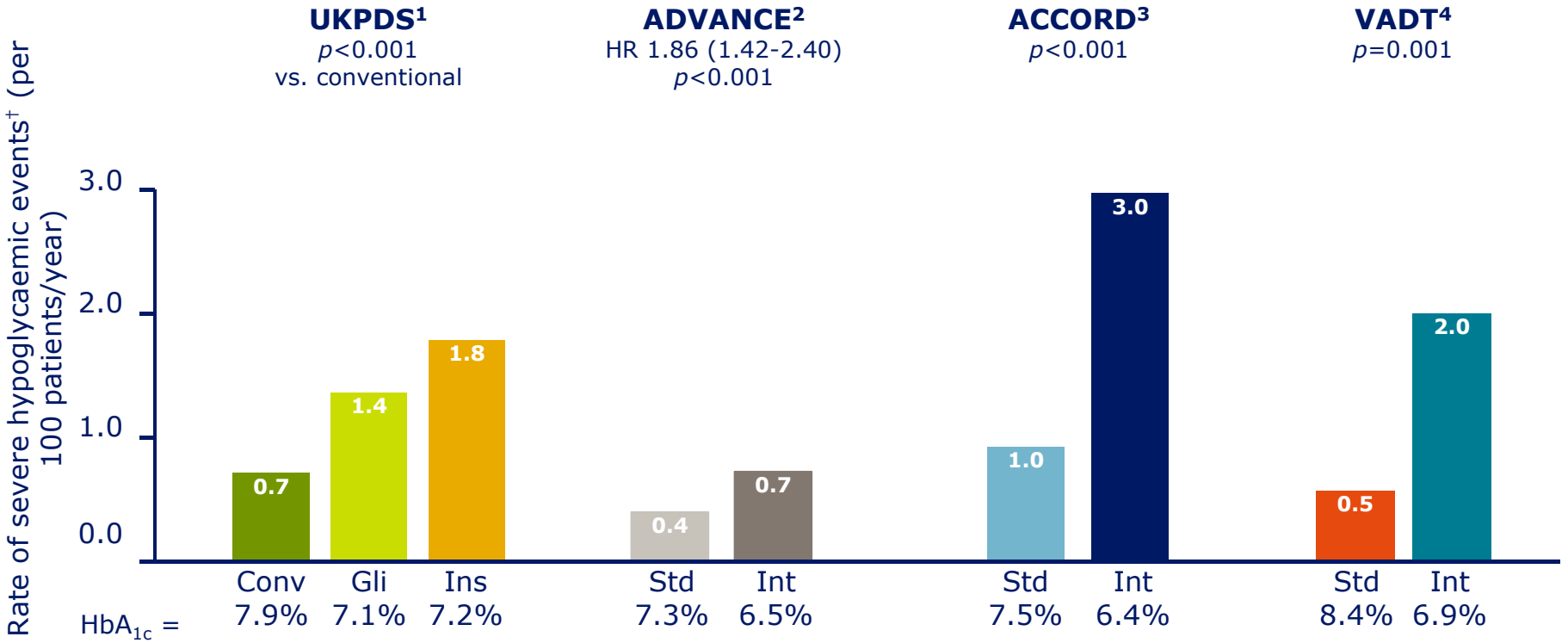
Guthrie B et al. *BMJ* 2012;345:e6341

Higher rate of severe hypoglycaemia with intensive glycaemic control*



*Intensive glycaemic control was defined differently in these trials
†Hypoglycaemia requiring any assistance in glucose-lowering trials
Conv, conventional therapy; gli, glibenclamide; HR, hazard ratio; ins, insulin; int, intensive therapy; std, standard therapy

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1. UKPDS Group *Lancet* 1998;352:837–853; 2. Patel A et al. ADVANCE Collaborative Group *N Engl J Med* 2008;358:2560–2572; 3. Gerstein HC et al. ACCORD Group. *N Engl J Med* 2008;358:2545–2559; 4. Duckworth W et al. *N Engl J Med* 2009;360:129–139

Physician barriers

- Physicians may be reluctant to initiate insulin due to:[1-3]
  - beliefs about patient risk
  - excess weight gain
  - risks in patients with comorbidities
  - hypoglycaemia
  - impaired quality of life
  - resource issues
  - beliefs about patient competence

1. Peyrot *et al. Diabetes Care* 2005;28:2673–9; 2. Elgrably *et al. Diabet Med* 1991;8:773–7; 3. Wallace & Matthews. *QJM* 2000;93:369–74

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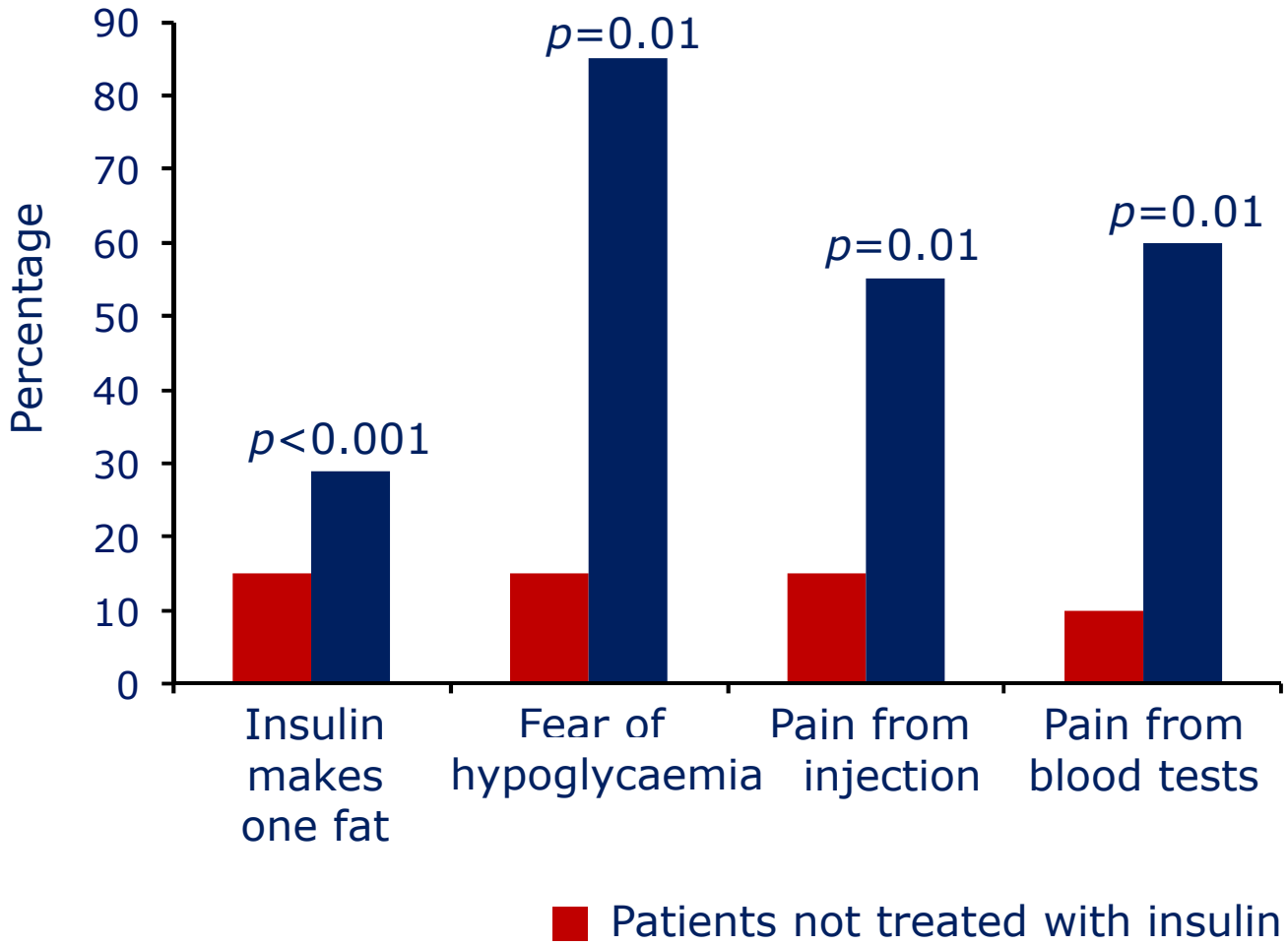
Barriers to insulin initiation



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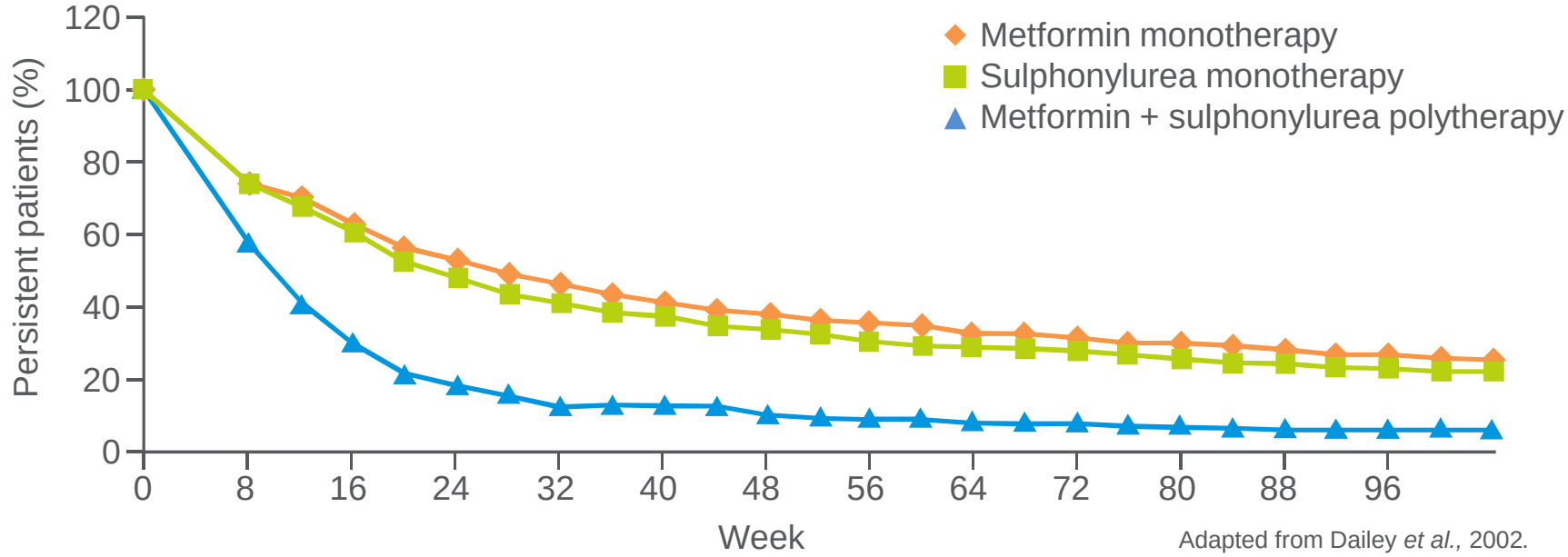
Nakar *et al. J Diabetes Complications* 2007;21:220–6

Many patients with diabetes do not adhere to their treatment

- Poor patient adherence is an important barrier to glycaemic control[1]
- Retrospective studies in people with Type 2 diabetes reported adherence rates of 36–93% for oral agents and 62–64% for insulin[1]
- Therapy persistence has been shown to decrease with time, and with polytherapy compared with monotherapy[2]



Adapted from Dailey *et al.*, 2002.

1. Cramer JA. *Diabetes Care* 2004;**27**:1218–1224.
2. Dailey G *et al. J Int Med Res* 2002;**30**:71–79.

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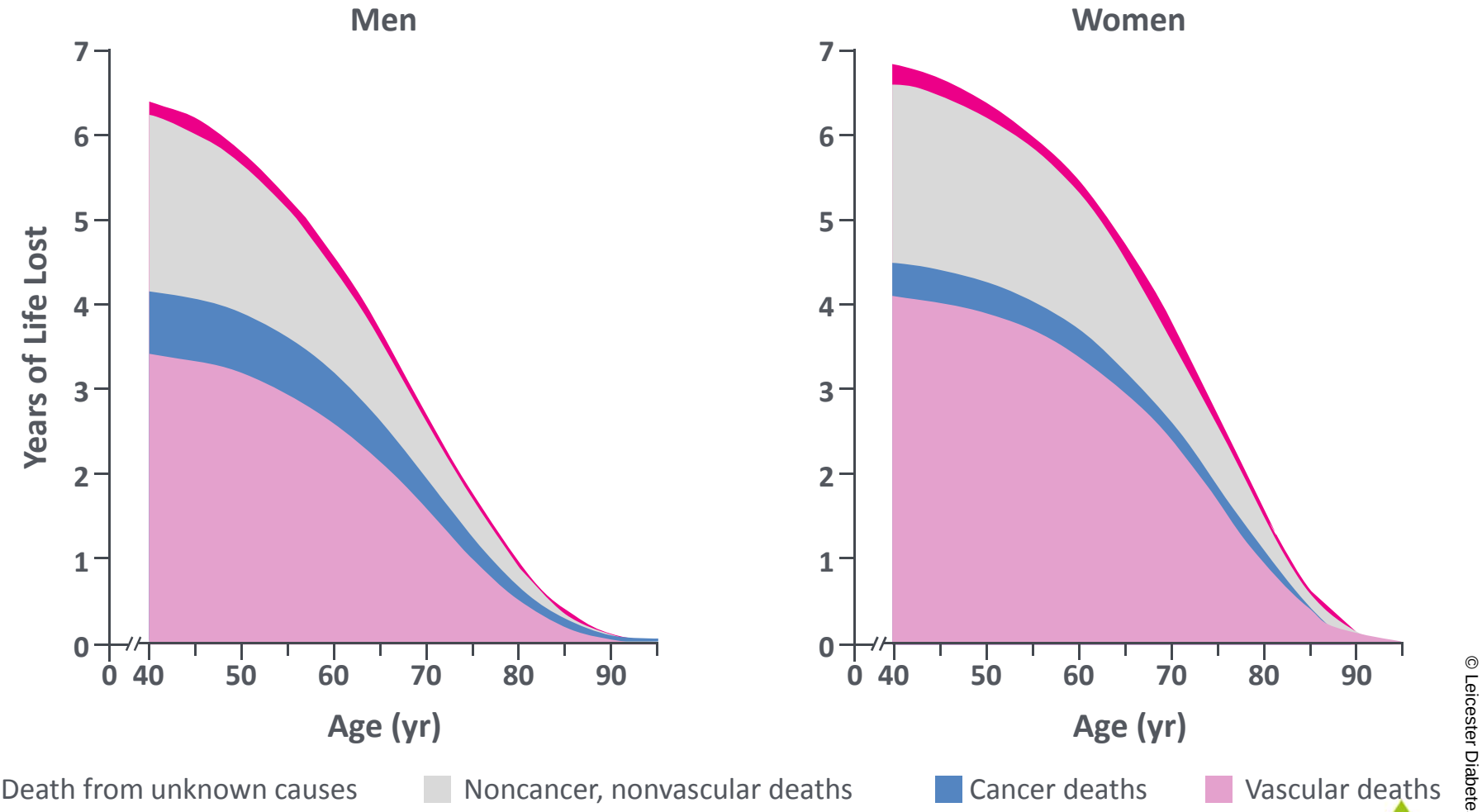
Elderly patients



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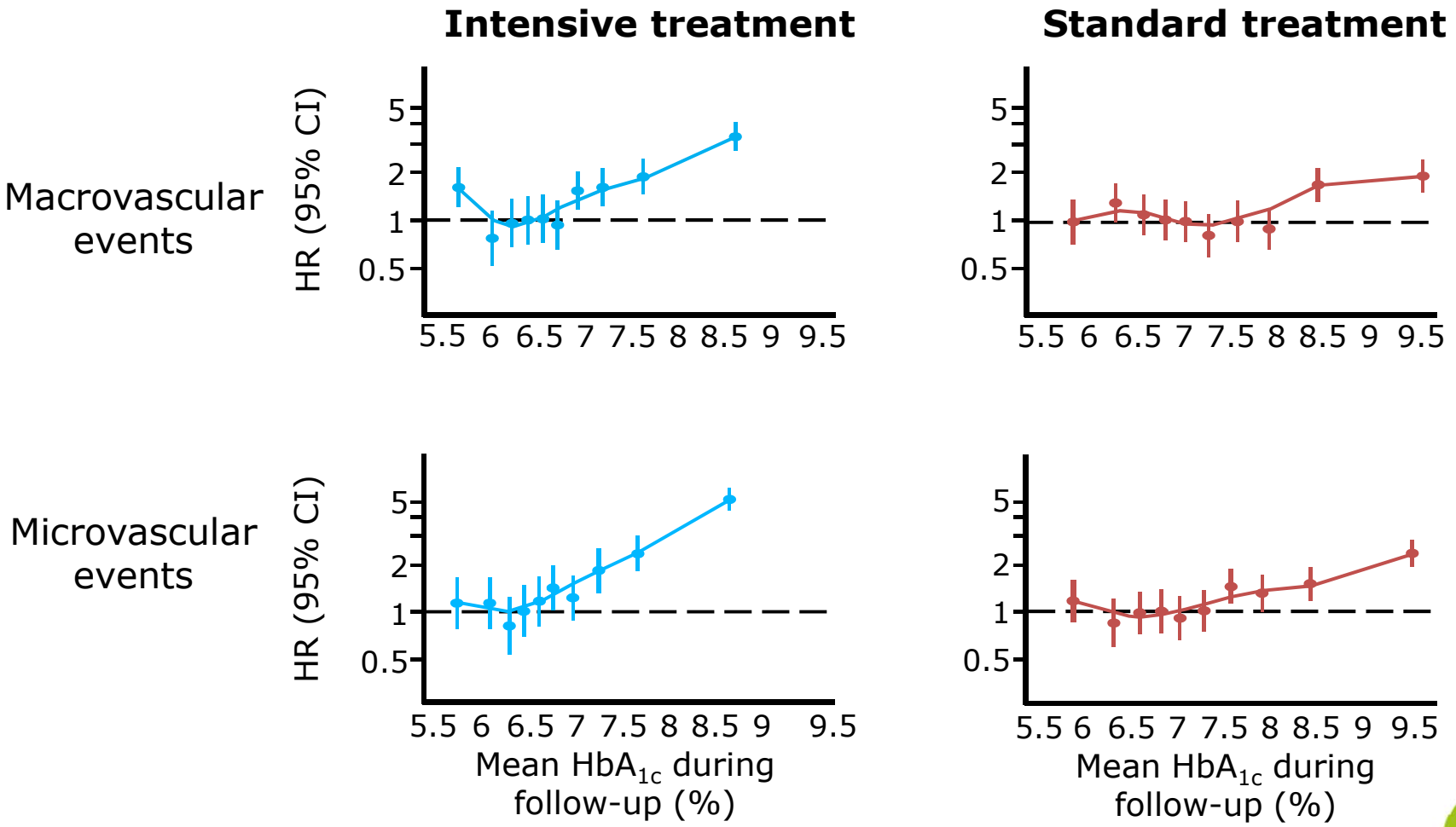
ERFC (Emerging Risk Factor Collaboration). *NEJM* 2011;364:829-841.

ADVANCE: HbA_{1c} vs. major macrovascular and microvascular event outcome



Mean age 66 years

CI, confidence interval; HR, hazard ratio

Zoungas S, et al. *Diabetologia* 2012;55:636–43.

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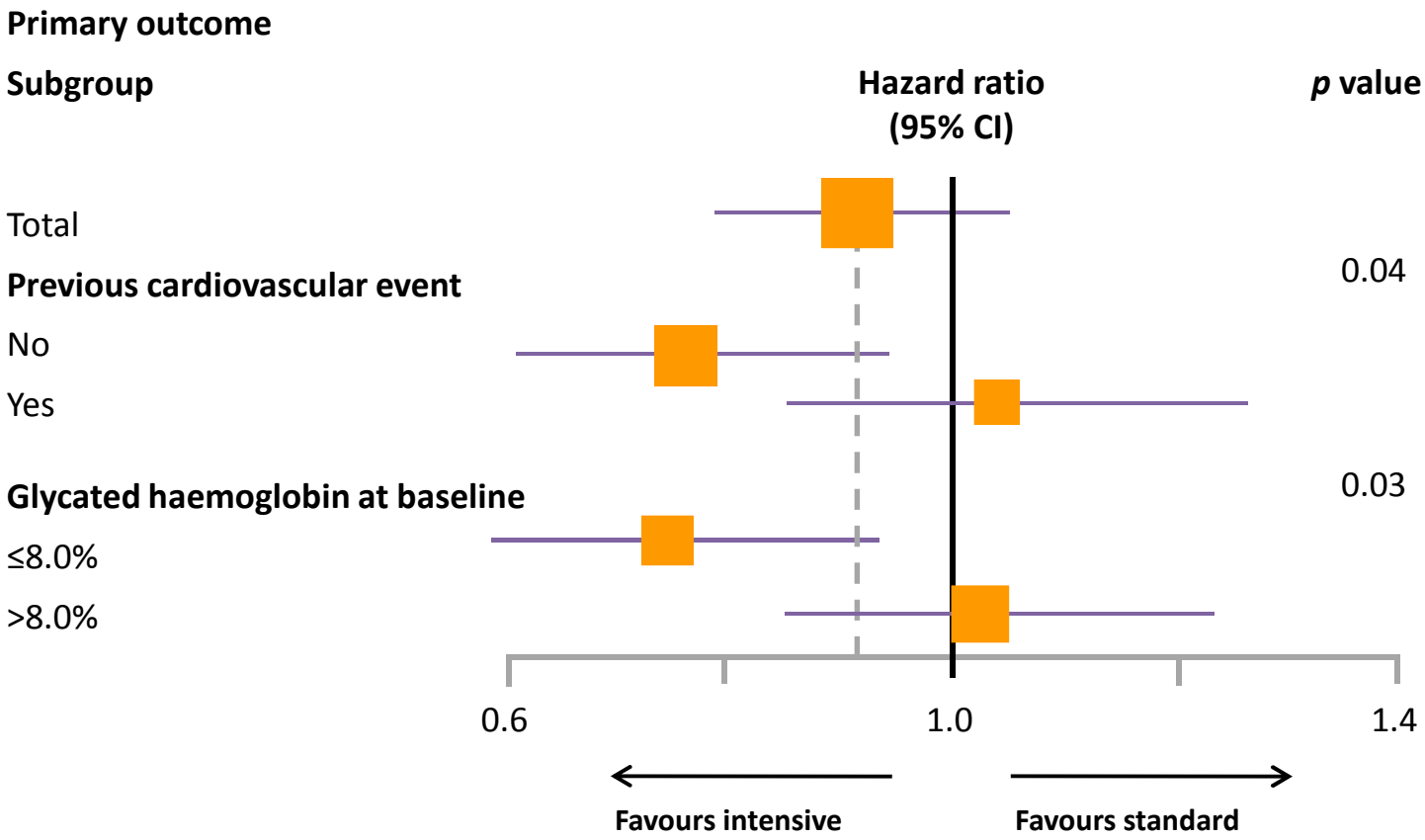
ACCORD: Intensive glucose control beneficial in patients with no previous CVD or HbA1c <8%



The vertical dashed line indicates the overall hazard ratio.
The size of each square is proportional to the number of patients.

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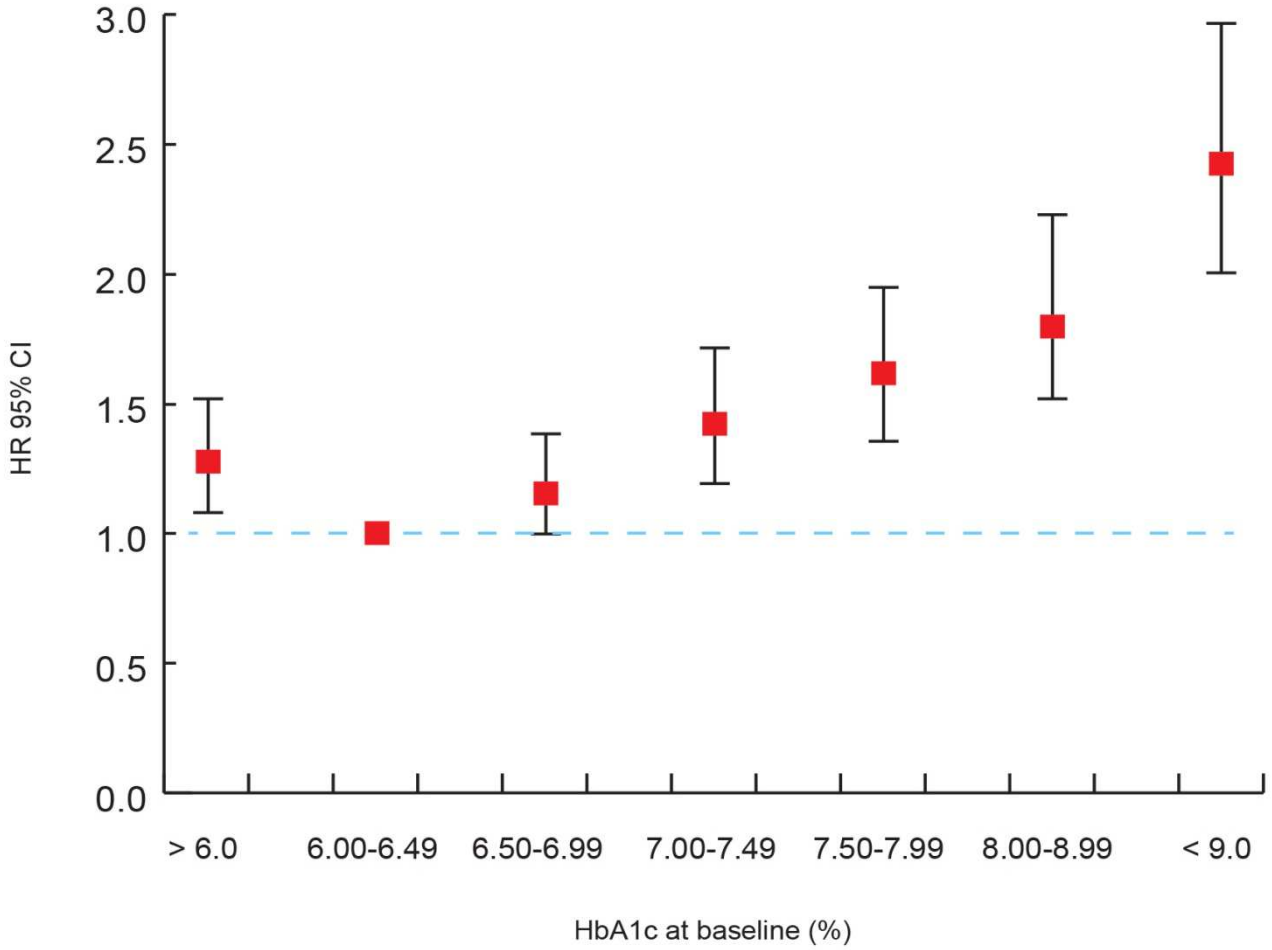
ACCORD Study Group. *N Engl J Med* 2008;358:2545-2559.

Individuals without cardiovascular disease



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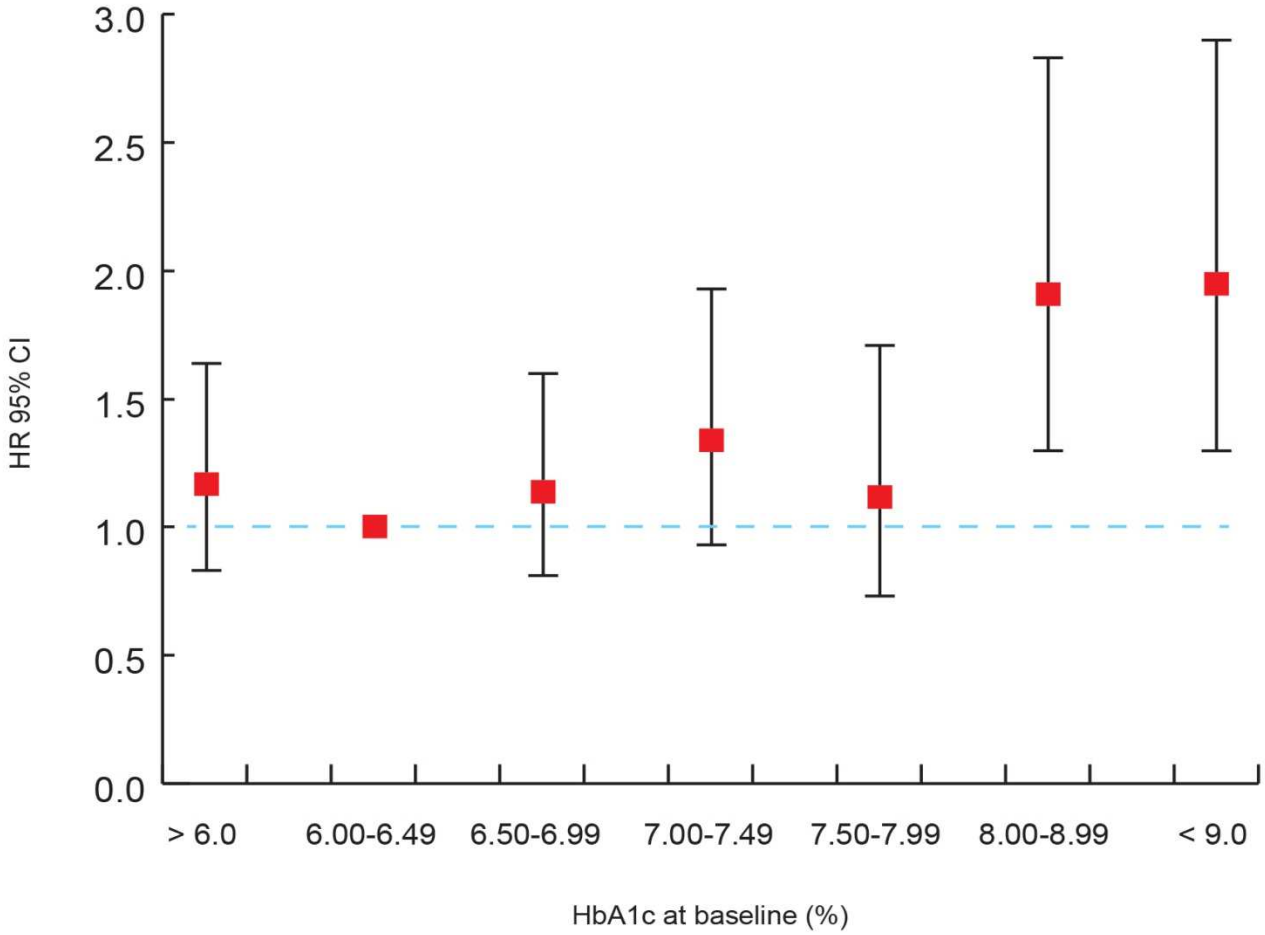
Khunti K, *et al. Br J Diab & Vasc Dis*;13:22-30.

Individuals with cardiovascular disease



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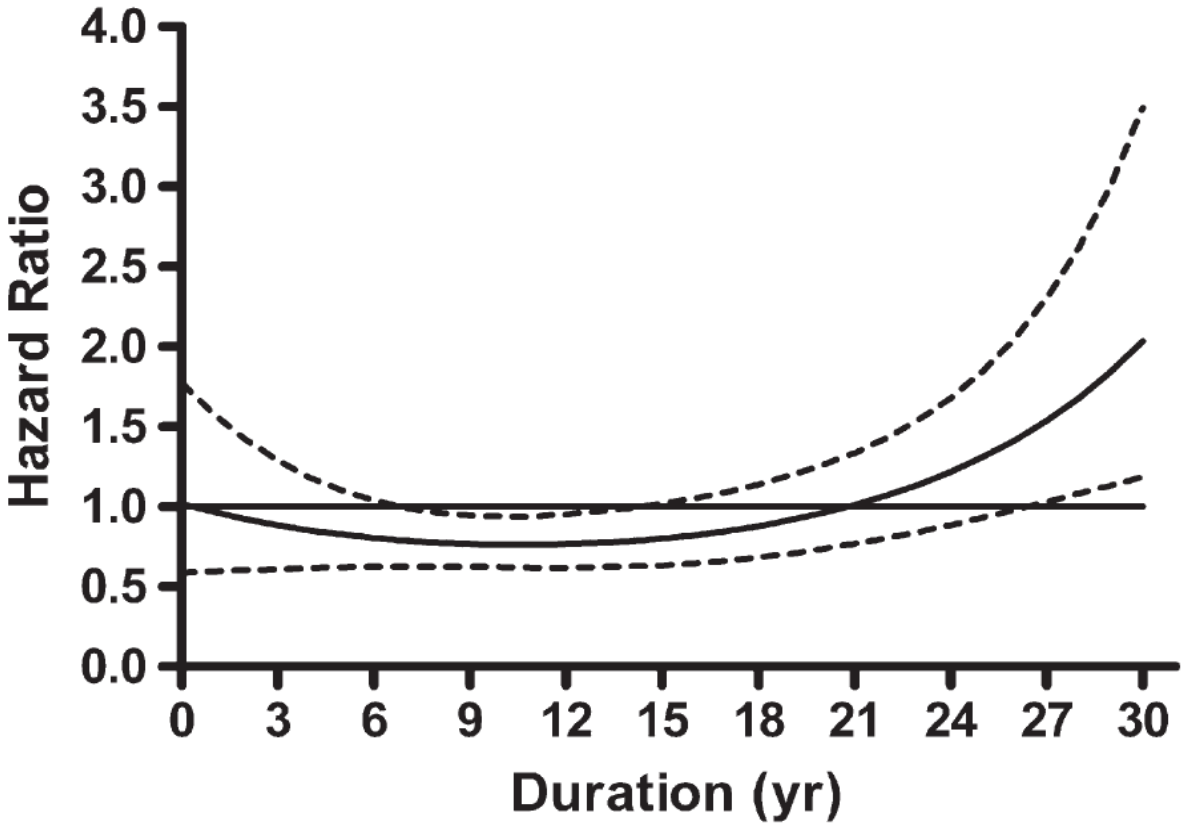
Khunti K, *et al. Br J Diab & Vasc Dis*;13:22-30.

Duration of diabetes and CVD risk in VADT



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Duckworth WC, *et al. J Diabetes Complications* 2011;25:355-361.

How can we improve the achievement of HbA_{1c} targets?

- Education (CME)
- Developing quality measures
- Motivating and supporting patients on self-management
- Effective use of information system
- Adherence to medications
- Adherence to guidelines
- Personal feedback to HCPs

CME, continuing medical education; HCP, healthcare practitioner

Zafar *et al. Primary Care Diabetes* 2010;4:203–7

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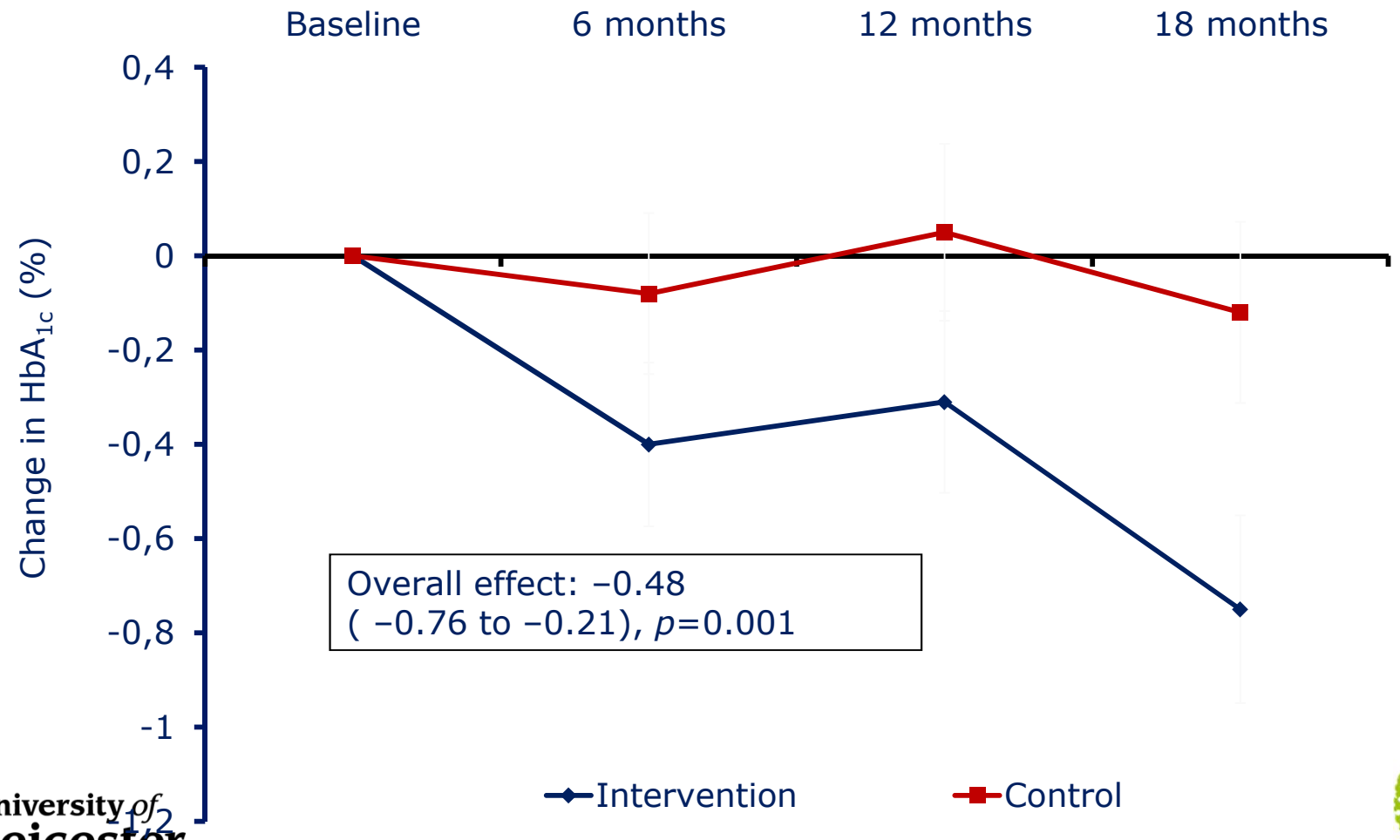
Multifactorial intervention in individuals with type 2 diabetes and microalbuminuria: MEMO study



Crasto *et al. Diabet Res Clin Pract* 2011;93(3):328-36

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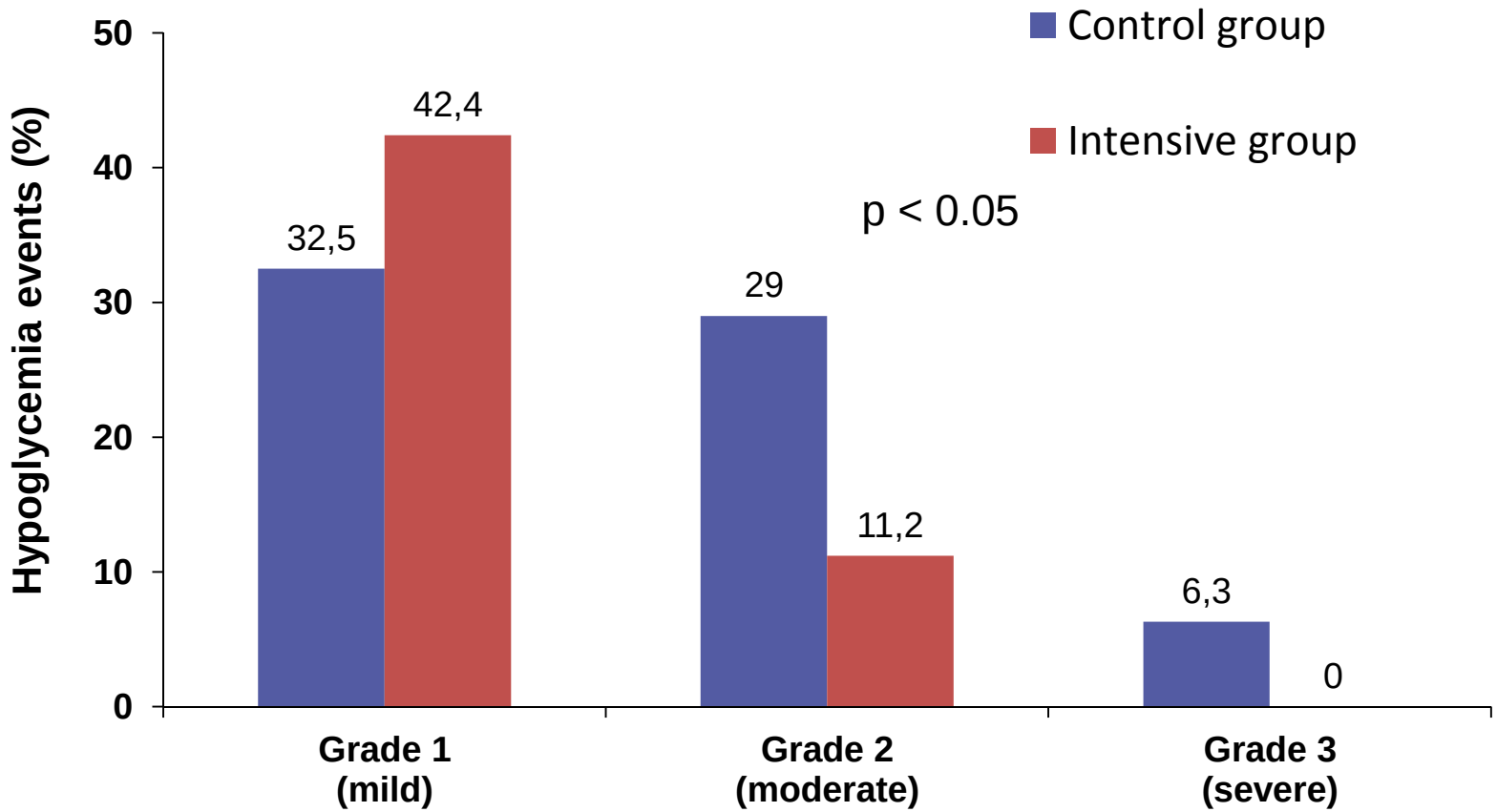
Impact of education on hypoglycaemia



Grade 1 (minor) hypoglycaemia was defined as the presence of hypoglycaemic symptoms with a self-measured capillary blood glucose of 3.1 mmol/L and self-treated; **Grade 2 (moderate)** hypoglycaemia was defined as a self-measured plasma glucose of < 3.1 mmol/L and self-treated; **Grade 3 (major)** hypoglycaemia was defined as requiring the assistance of another person.

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Crasto et al. Diabet Res Clin Pract. 2011;93:328-36.

Tratamiento intensivo precoz

- Guias/recomendaciones Tto. Diabetes
- “La vida real”
- Complejidad de la individualización
- Tratamiento intensivo precoz
- Take-home messages

Mixed results on tight and rapid HbA1c control

Study	HbA1c (%)		Impact of intensive therapy vs standard therapy on outcome		
	Standard therapy	Intensive therapy	Microvascular	CVD	Mortality
ACCORD	7.5	6.4	?	↔	↑
ADVANCE	7.3	6.5	↓	↔	↔
VADT	8.4	6.9	↔	↔	↔
UKPDS	7.9	7.0	↓	↔	↔
UKPDS – follow-up	~7.9	~7.9	↓	↓*	↓

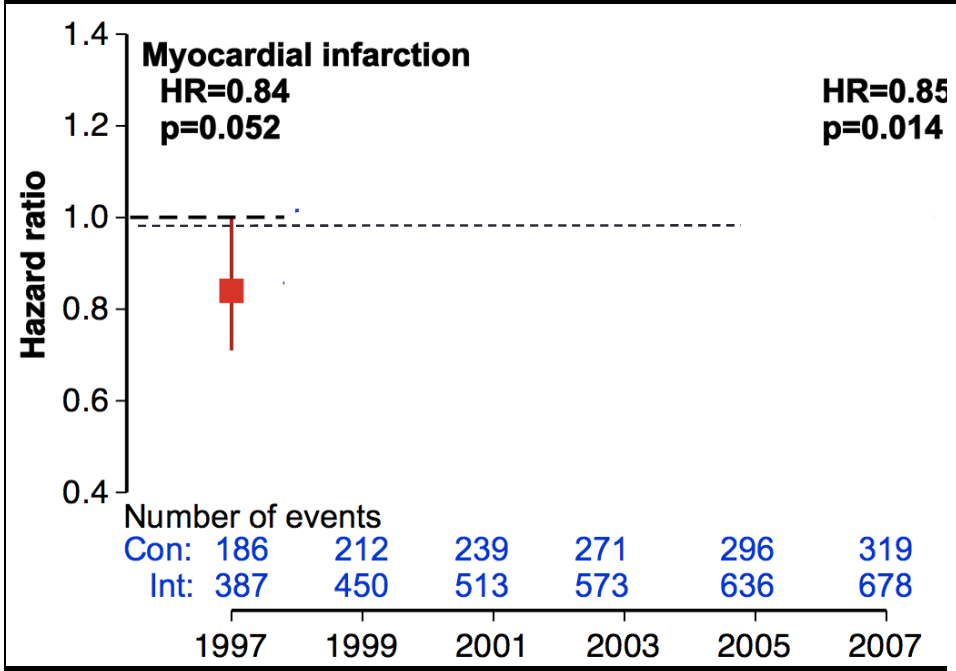
* Reduction in myocardial infarction

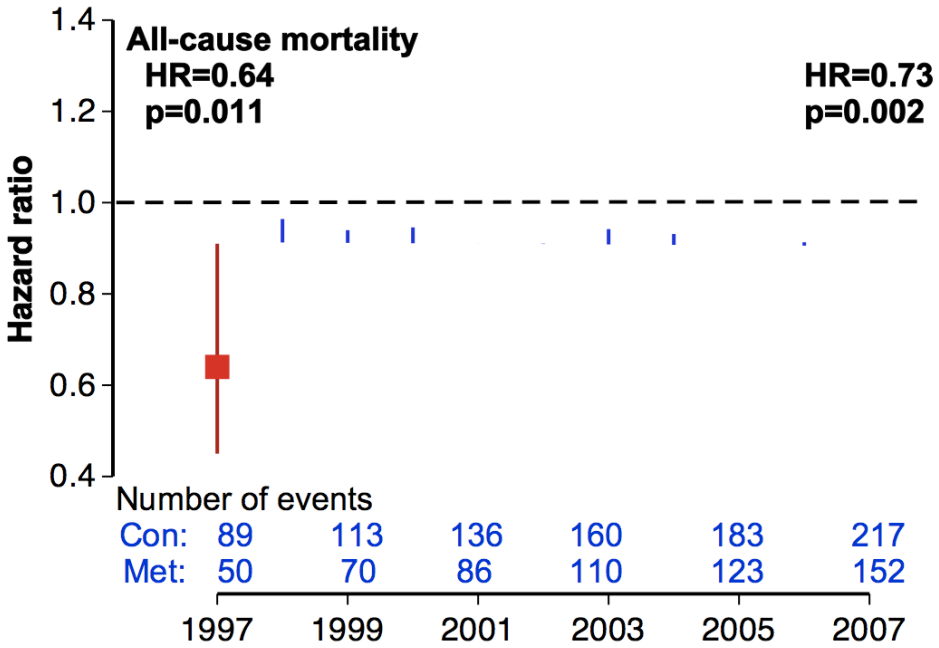
ACCORD Study Group. *N Engl J Med* 2008;358:2545-2559;
ADVANCE Collaborative Group. *N Engl J Med* 2008;358:2560-2572;
Duckworth W, *et al. N Engl J Med* 2009;360:129-139;
UKPDS. *Lancet* 1998;352:837-853;
Holman RR, *et al. N Engl J Med* 2008;359:1577-1589.

“The legacy effect”

SU / Insulina

Metformina

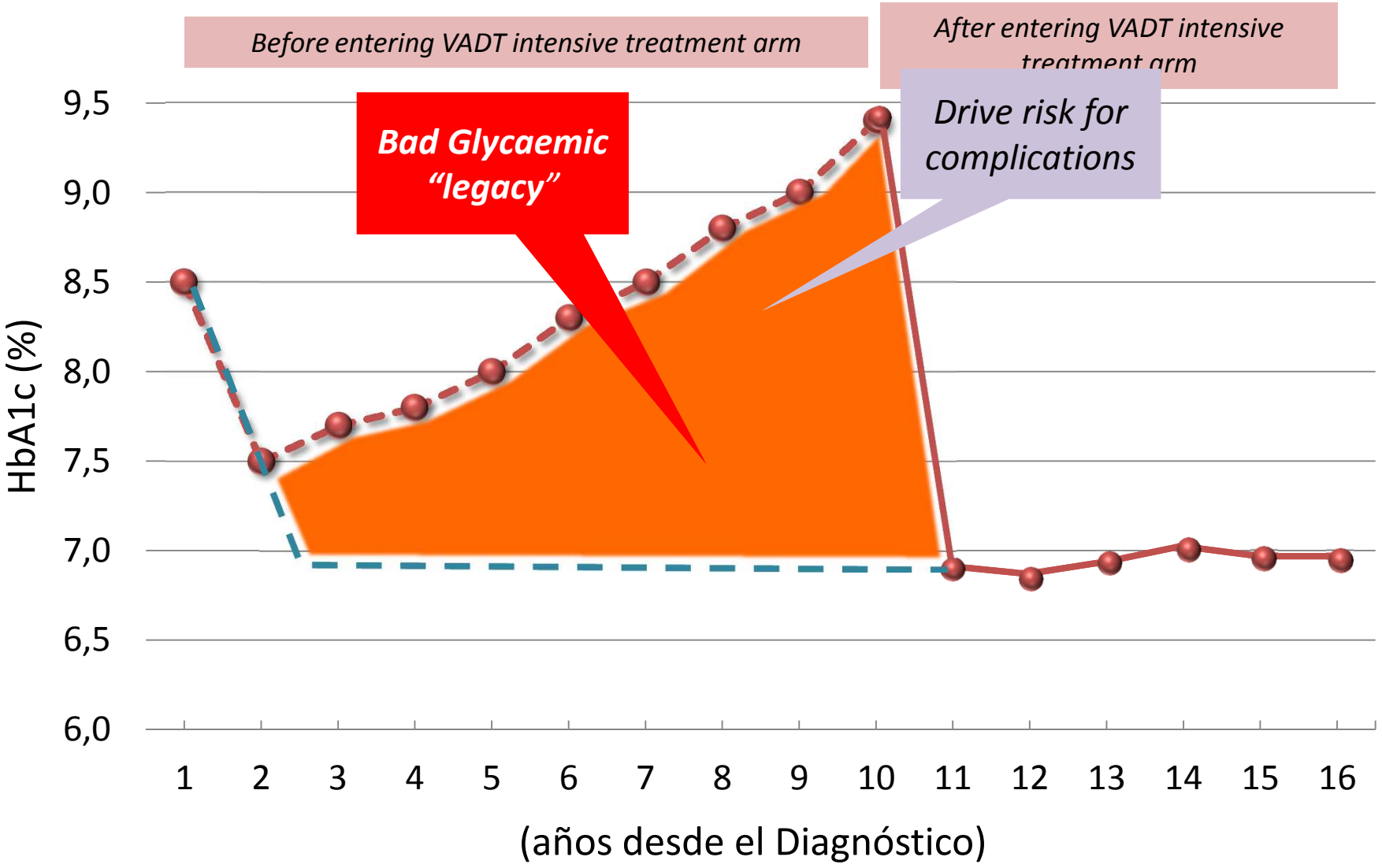




Holman RR et al. ***N Engl J Med***. 2008;359:1577–1589

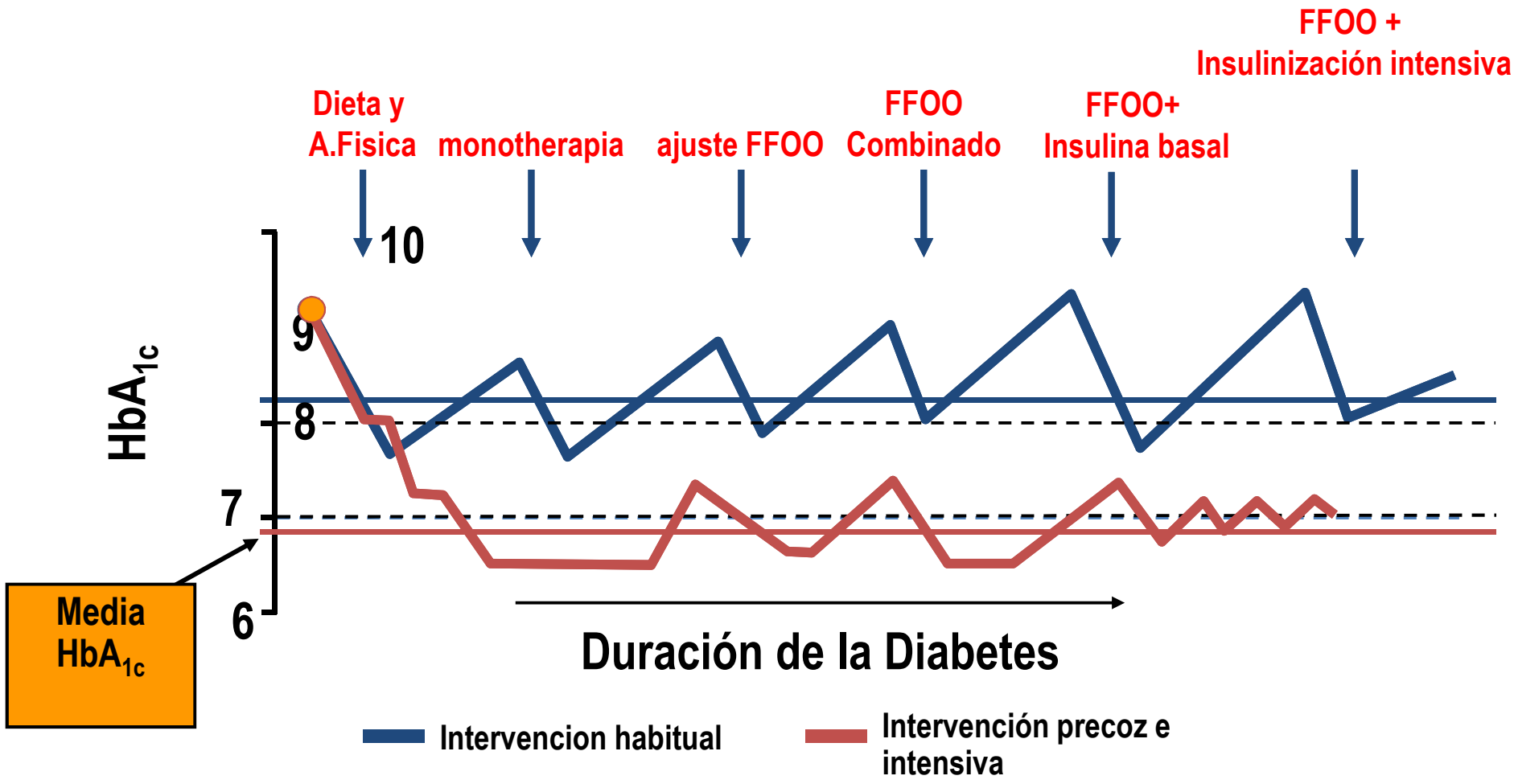
*De Vries JH ***Diabetologia***. 2011;54:705–706

Consecuencias de la demora de la intervención
Interpretación de VADT



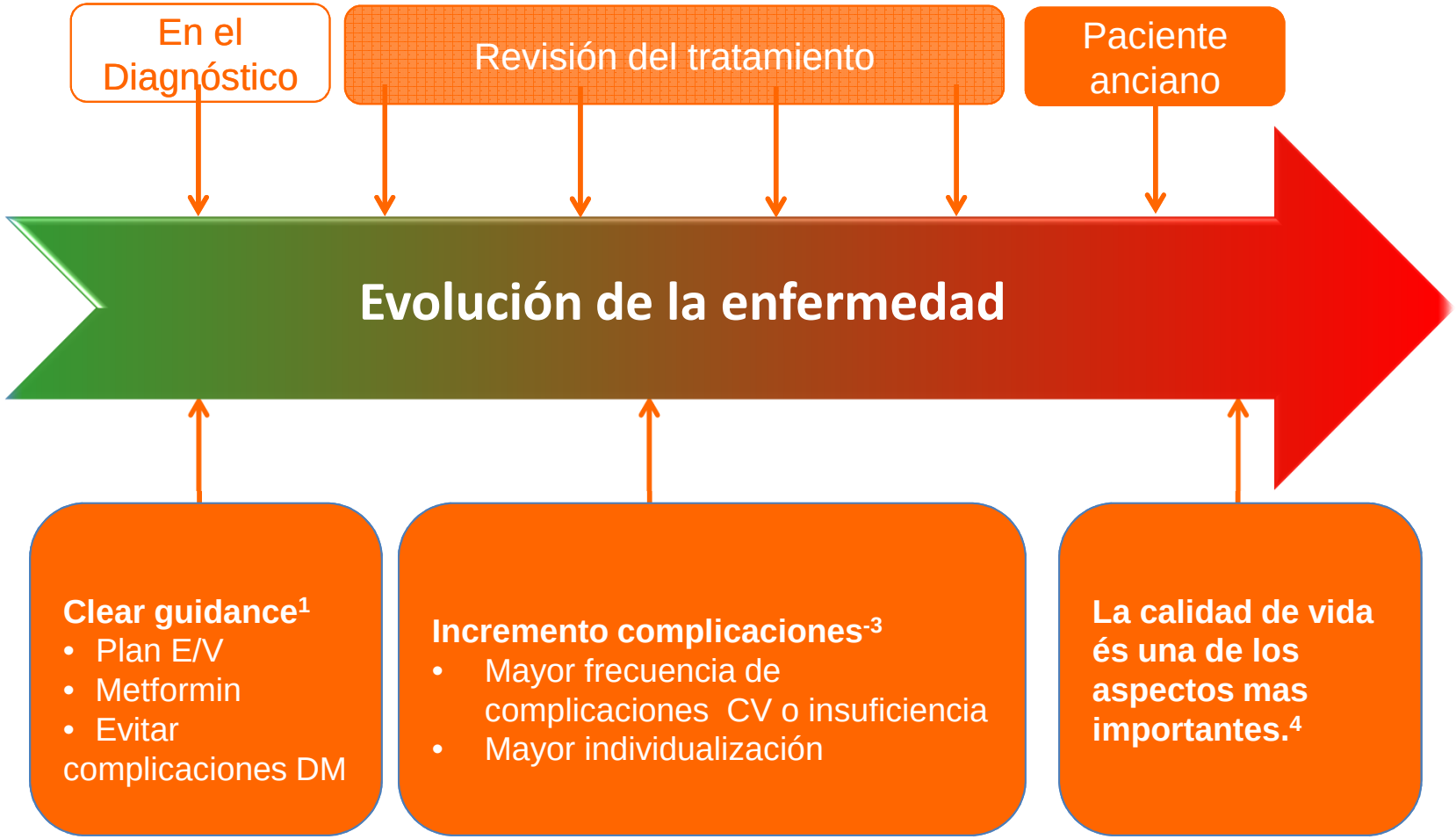
Del Prato S Diabetologia 2009;52:1219

Intervención precoz / logro de objetivos?



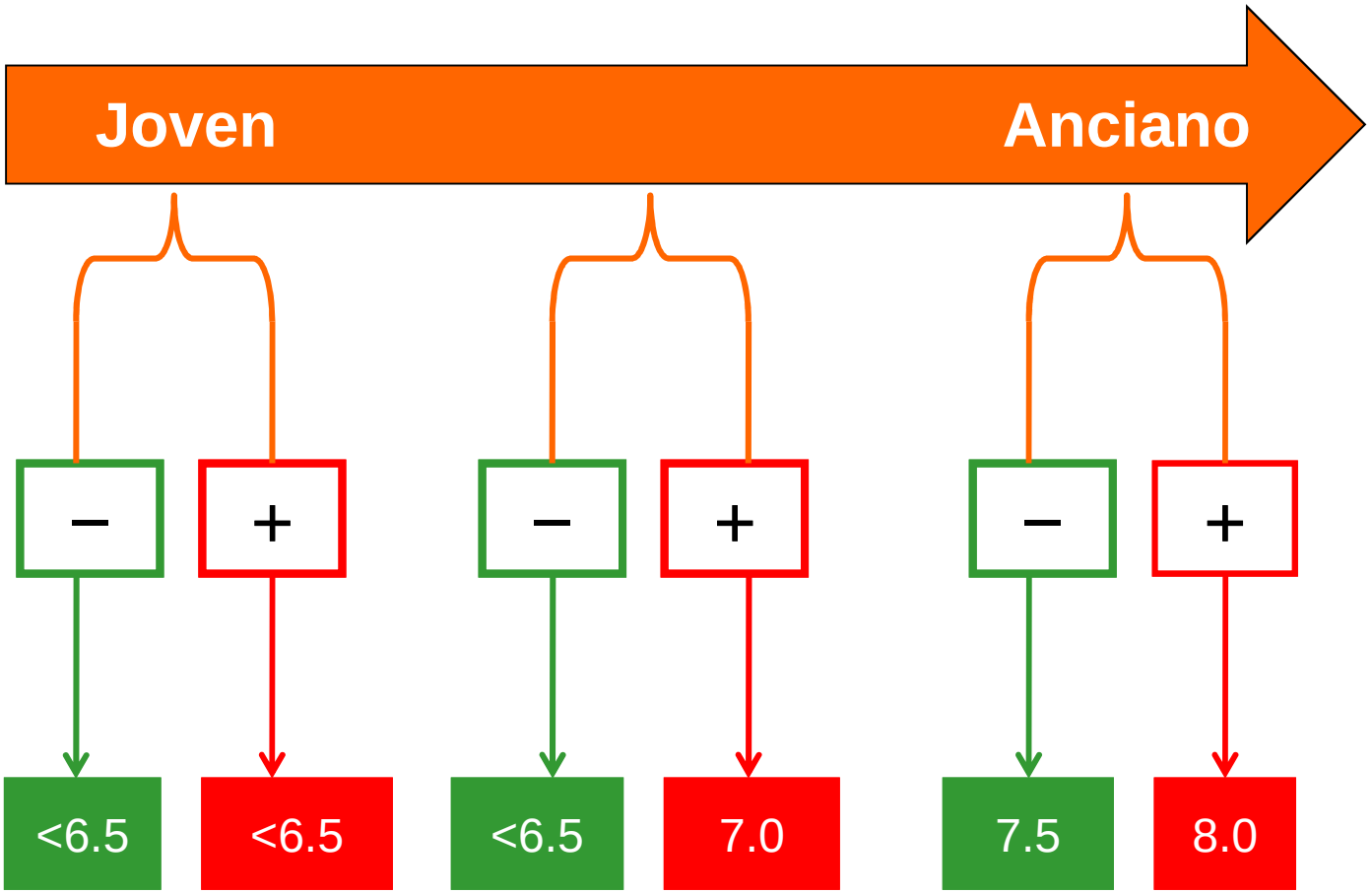
Del Prato S et al. Int J Clin Pract. 2005;59:1345–1355.

Complejidad progresiva del manejo de la DM2



1,2. Adapted from National Institute for Health and Clinical Excellence. Clinical Guideline 87. Type 2 diabetes – newer agents (a partial update of CG66): quick reference guide. NICE clinical guideline 66: Type 2 Diabetes Management. Available at: http://www.nice.org.uk/nicemedia/pdf/CG66NICEGuideline.pdf (accessed November 2012).
3. Go AS, et al. *N Engl J Med.* 2004;351:1296–1305; 4. Morley JE. *Diabet Med.* 1998;15 (Suppl. 4): S41–6.

Individualización terapéutica



Factores a valorar:
- Complicaciones (macro/micro)
- Hipoglucemia
- Duración (>10 yrs)
- HBA_{1c} > 8-9%
- Objetivos complejos

HbA_{1c} (%)

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Take-home messages

- Las guias y recomendaciones actuales recomiendan un control glucémico estricto desde las fases iniciales de la enfermedad
- Existen varias barreras que dificultan un control estricto
- Son necesarias diferentes soluciones desde diversos areas
- Las estrategias incluyen
  - Mejorar los conocimientos y su implementación por sanitarios y pacientes
  - Proporcionar ayudas de prescripción
  - Incrementar la eficiencia del trabajo en equipo
  - Comunicación

Gracias

@kamleshKhunti
@Xaviercos