XVII Reunión
Insuficiencia Cardiaca
y Fibrilación Auricular

SEMI
SOCIEDAD ESPAÑOLA DE MEDICINA INTERNA
LA VISIÓN GLOBAL DE LA PERSONA ENFERMA

FEMI
FUNDACIÓN ESPAÑOLA DE MEDICINA INTERNA

GRUPO DE INSUFICIENCIA CARDÍACA Y FIBRILACIÓN AURICULAR

16-17 de Abril de 2015
Hotel Holiday Inn-Madrid

CONSIDERACIONES ESPECIALES DEL TRATAMIENTO DE LA DIABETES EN EL PACIENTE ANCIANO CON IC

Dr. Fco. Javier Carrasco
Complejo Hospitalario Universitario de Huelva

Conflicto de Intereses

Ponencias, trabajos científicos y panel de asesores para

Novo-Nordisk

Sanofi-Aventis

Novartis

Lilly

Boehringer-Ingelheim

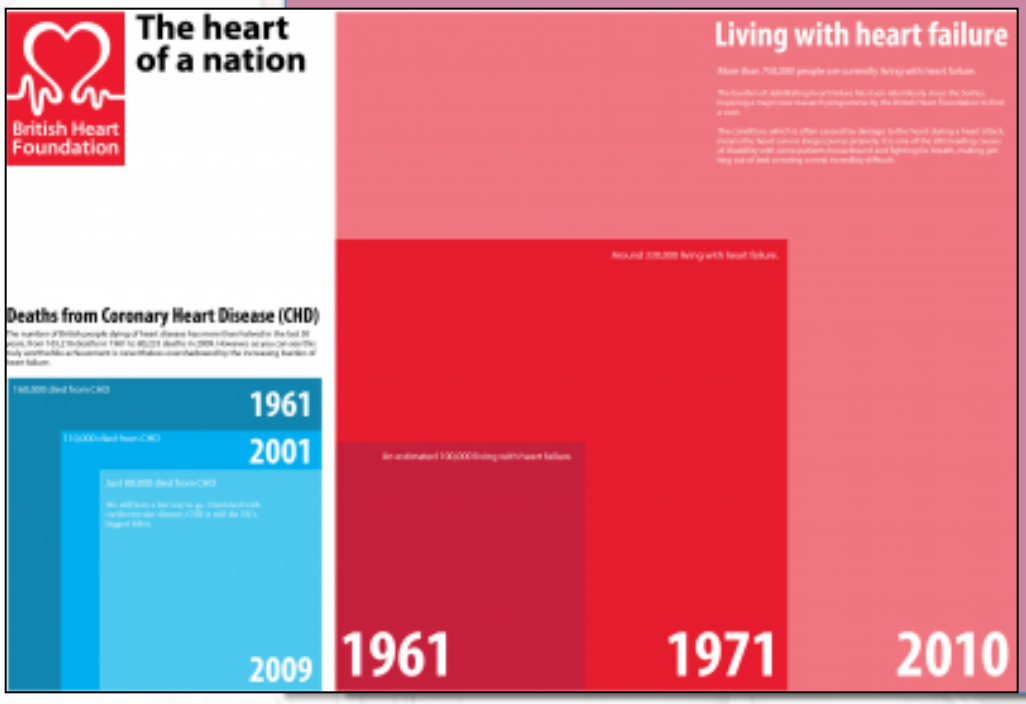
Astra-Zeneca

Almirall

Jassen

- DIMENSIÓN DEL TEMA
- ANCIANOS COMO POBLACIÓN ESPECIAL
- REVISIÓN FÁRMACOS
- INCRETINAS: ICC
- RECOMENDACIONES

Incidencia exponencial de la INSUFICIENCIA CARDIACA



2020

2030

ESTIMACIÓN PREVALENCIA DIABETES

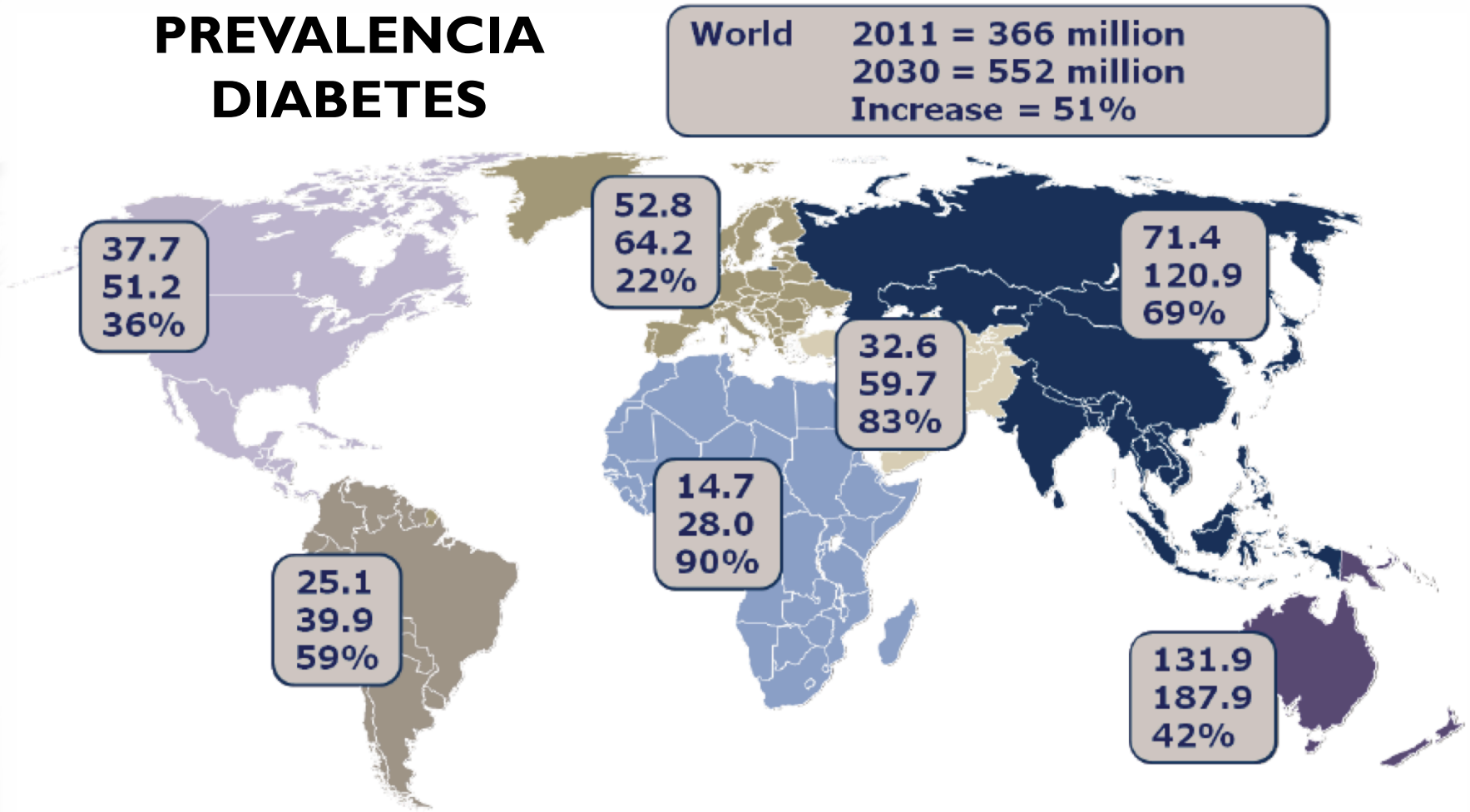
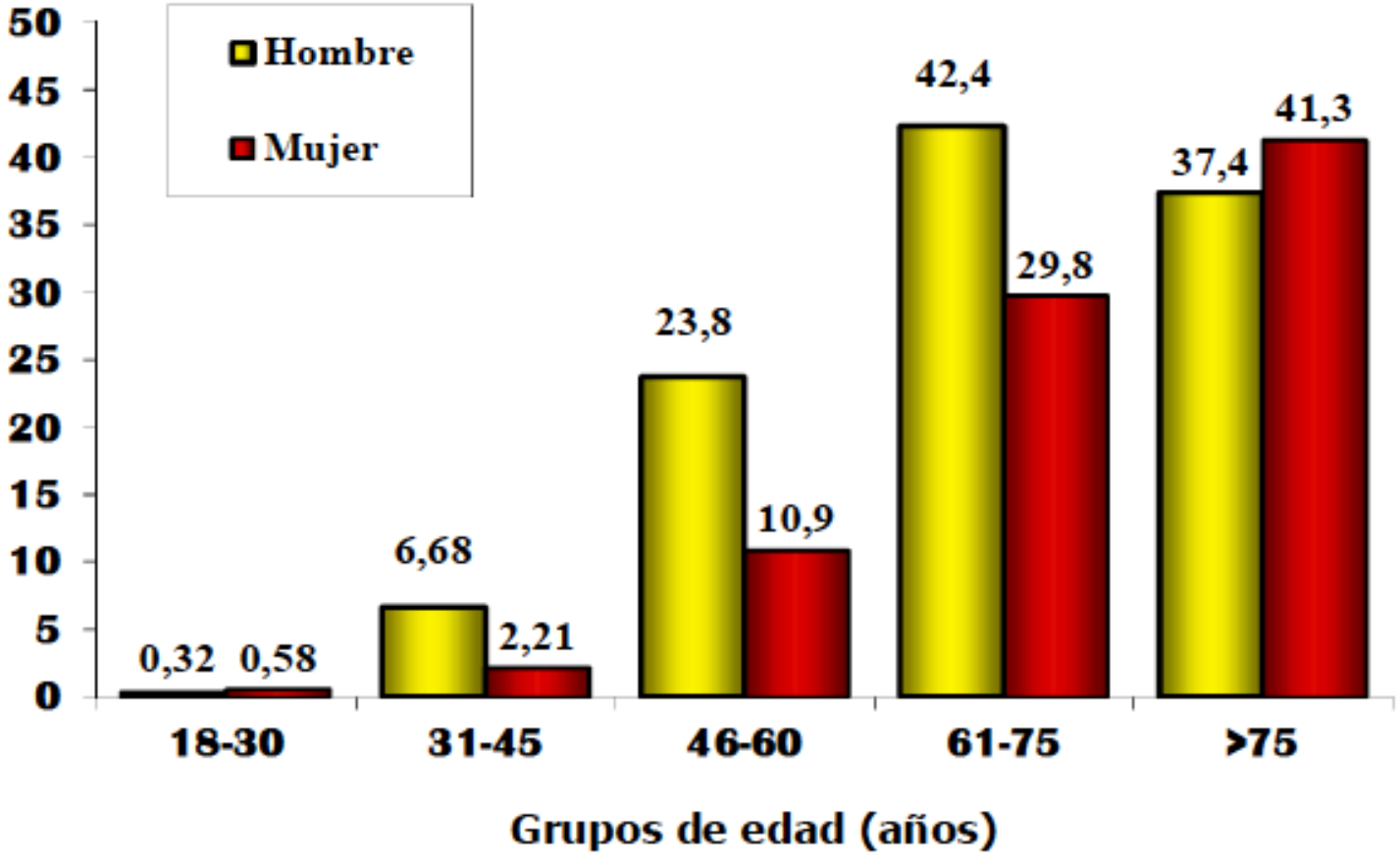


Figura 1: Prevalencia Diabetes en España: Distribución por sexo y grupos de edad en %



Di@bet.es Study; Diabetologia 2012; 55: 88-93.

DIABETES RESEARCH AND CLINICAL PRACTICE 104 (2014) 410–419

Contents available at ScienceDirect

Diabetes Research and Clinical Practice

journal homepage: www.elsevier.com/locate/diabres

ELSEVIER

International Diabetes Federation

Association between type-2 diabetes mellitus and post-discharge outcomes in heart failure patients: Findings from the RICA registry

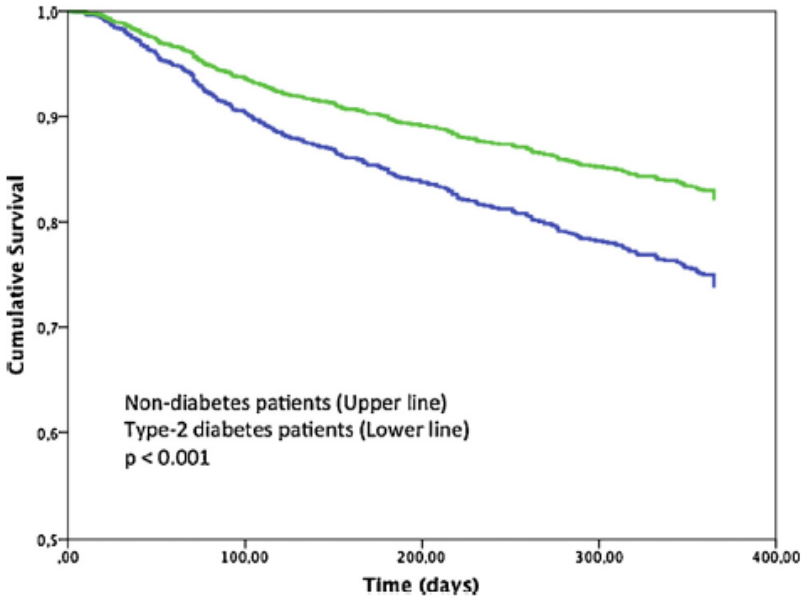


Fig. 1 – Adjusted impact on survival in heart failure patients with type-2 diabetes mellitus after discharge. Kaplan-

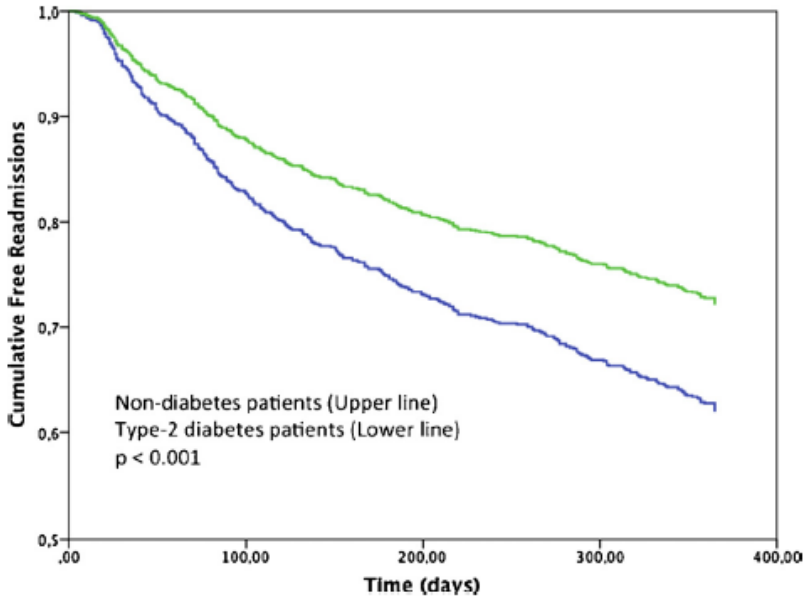
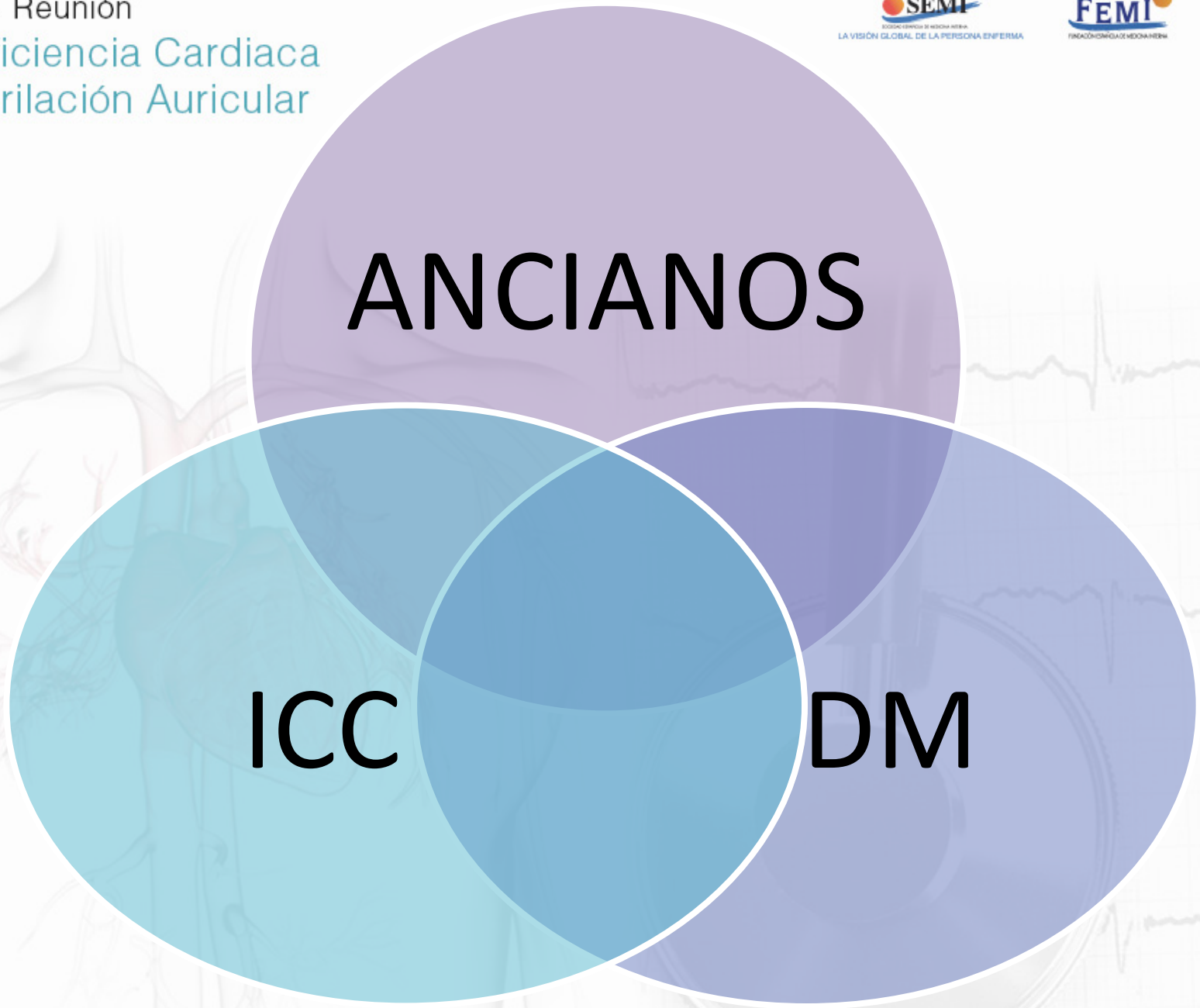
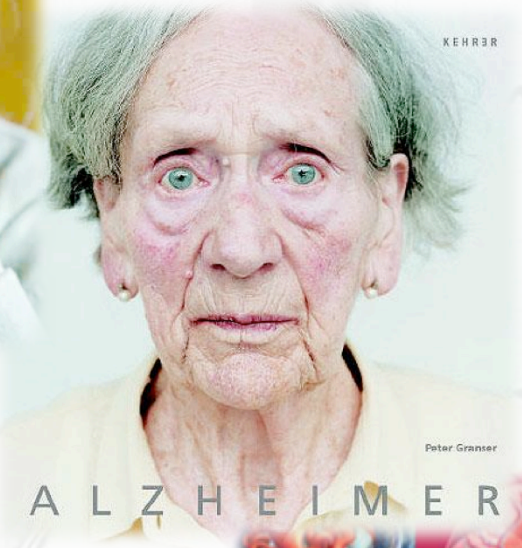
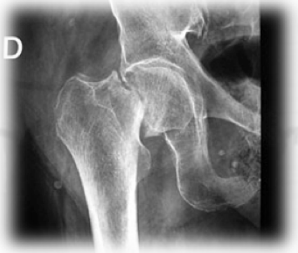
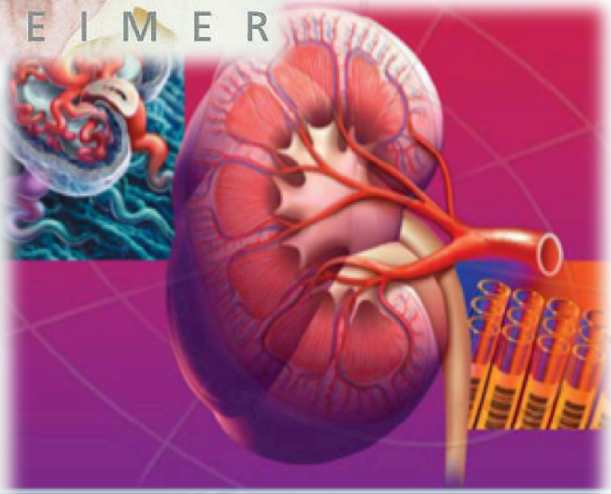


Fig. 2 – Adjusted impact on readmissions in heart failure patients with type-2 diabetes mellitus after discharge.


ANCIANOS
ICC
DM


KEHRER
Peter Gransee
ALZHEIMER





XVII Reunión
Insuficiencia Cardiaca
y Fibrilación Auricular

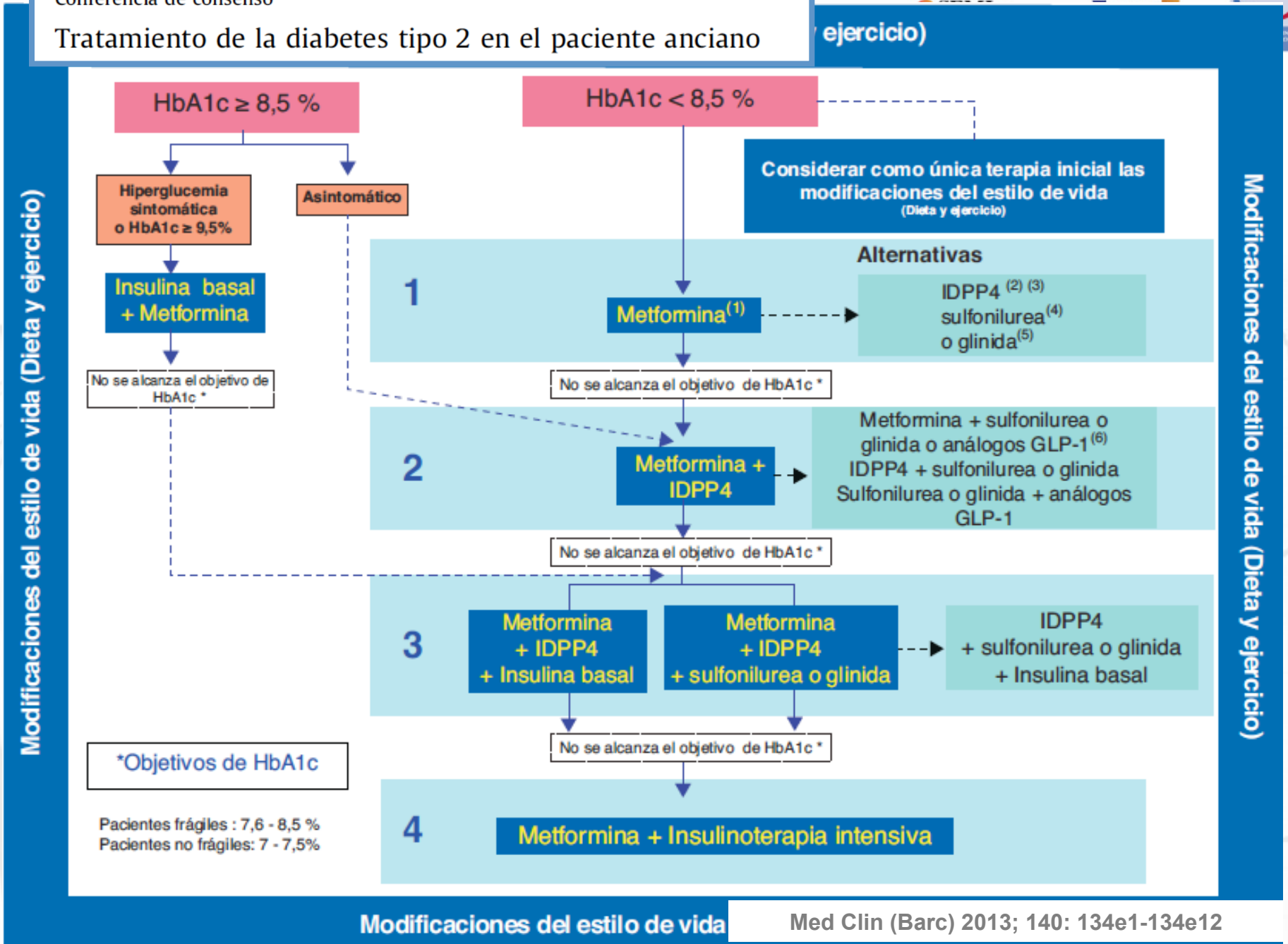
HIPOGLUCEMIA

XVII Reunión
Insuficiencia Cardiaca
y Fibrilación Auricular

Empezar Despacio
&
Continuar Despacio

Conferencia de consenso

Tratamiento de la diabetes tipo 2 en el paciente anciano

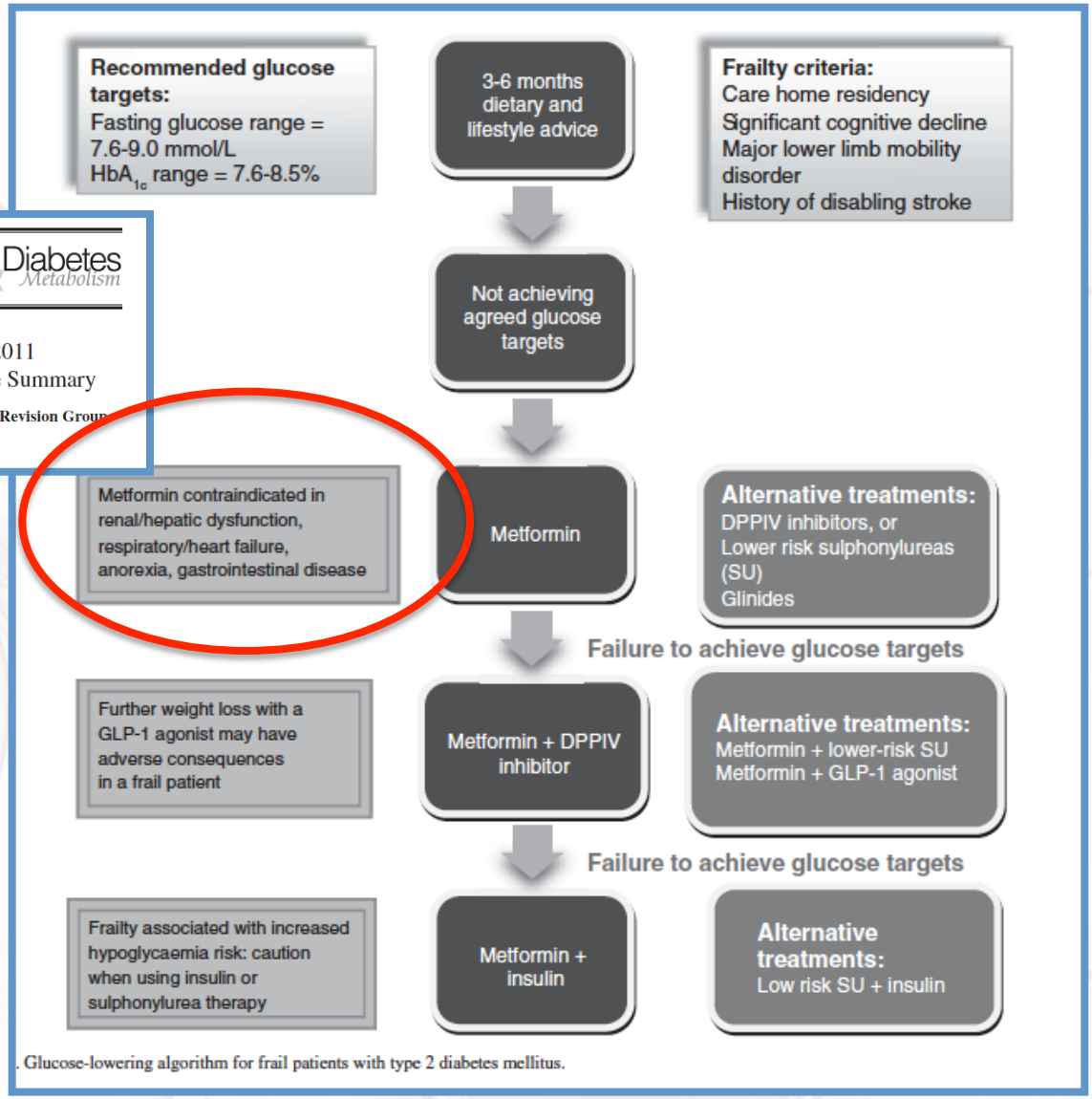


Med Clin (Barc) 2013; 140: 134e1-134e12

Disponible en ligne sur ScienceDirect www.sciencedirect.com
Elsevier Masson France EM|consulte www.em-consulte.com
Diabetes & Metabolism
ELSEVIER MASSON
Diabetes & Metabolism 37 (2011) S27-S38

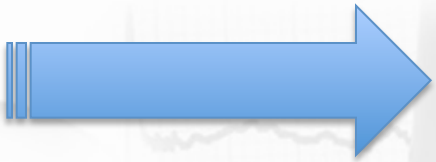
European Diabetes Working Party for Older People 2011
Clinical Guidelines for Type 2 Diabetes Mellitus. Executive Summary

A Report of the European Diabetes Working Party for Older People (EDWPOP) Revision Group on Clinical Practice Guidelines for Type 2 Diabetes Mellitus



. Glucose-lowering algorithm for frail patients with type 2 diabetes mellitus.

Fenformina



ACIDOSIS LACTICA

METFORMINA

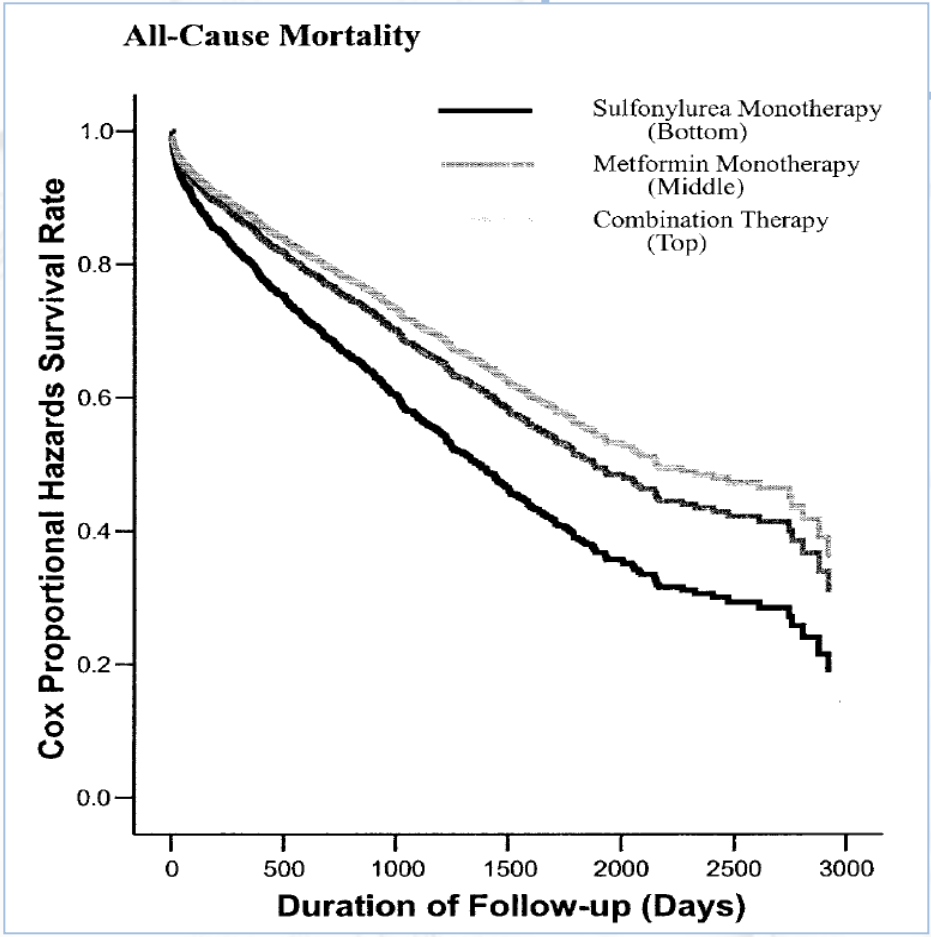
RESTRICCIÓN DE USO: I. RENAL – I. CARDIACA

¿SEGURA Y EFECTIVA?

Improved Clinical Outcomes Associated With Metformin in Patients With Diabetes and Heart Failure

Ross T. Tsuyuki, BSc(Pharm), PharmD, MSc[1,2,4]
Jeffrey A. Johnson, PhD[1,2]

Diabetes Care 2005; 28: 2345-51



Enfermedad renal crónica
Puede utilizarse en dosis plenas si FG > 45 ml/min
Reducir dosis si FG < 45 ml/min y suspender si FG < 30 ml/min
Contraindicada si Cr ≥ 1,5 mg/dl en varones o ≥ 1,4 mg/dl en mujeres

DISFUNCIÓN RENAL EN LA INSUFICIENCIA CARDIACA AGUDA

Comparative Safety and Effectiveness of Metformin in Patients With Diabetes Mellitus and Heart Failure

Systematic Review of Observational Studies Involving 34 000 Patients

Dean T. Eurich, PhD; Daniala L. Weir, BSc; Sumit R. Majumdar, MD, MPH; Ross T. Tsuyuki, PharmD, MSc; Jeffrey A. Johnson, PhD; Lisa Tjosvold, MLIS; Saskia E. Vanderloo, MSc; Finlay A. McAlister, MD, M

(*Circ Heart Fail.* 2013;6:395-402.)

Study or Subgroup	Metformin Events	Metformin Total	Control Events	Control Total	Weight	Risk Ratio M-H, Random, 95% CI	Year
Eurich	29	208	200	773	7.0%	0.54 [0.38, 0.77]	2005
Masoudi	460	1861	4345	12069	13.3%	0.69 [0.63, 0.75]	2005
Inzucchi	93	406	768	2184	11.0%	0.65 [0.54, 0.79]	2005
Andersson	239	688	2344	3615	12.9%	0.54 [0.48, 0.60]	2010
Roussel	221	1220	488	2790	12.0%	1.04 [0.90, 1.20]	2010
Evans	137	205	183	217	12.8%	0.79 [0.71, 0.89]	2010
Shah	22	99	112	302	6.2%	0.60 [0.40, 0.89]	2010
MacDonald	155	376	733	1306	12.4%	0.73 [0.65, 0.84]	2010
Aguilar	246	1561	1117	4624	12.5%	0.65 [0.58, 0.74]	2011
Total (95% CI)		**6624**		**27880**	**100.0%**	**0.69 [0.61, 0.79]**	
Total events	1602		10290				

Heterogeneity: $Tau^2 = 0.03$; $Chi^2 = 63.59$, df = 8 ($P < 0.00001$); $I^2 = 87\%$

Test for overall effect: $Z = 5.45$ ($P < 0.00001$)

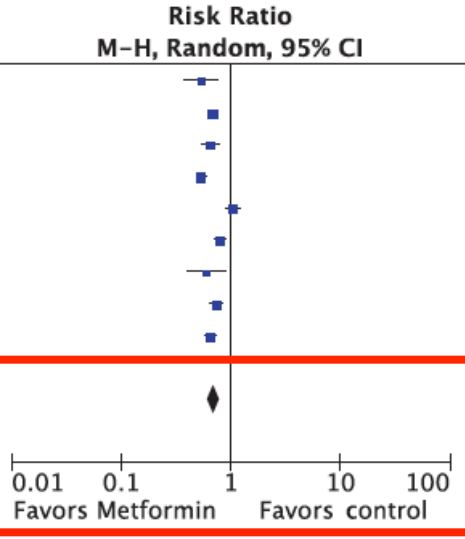


Figure 2. Pooled unadjusted risk ratios for metformin compared with other treatments for all-cause mortality. CI indicates confidence interval.

SULFONILUREAS

HIPOGLUCEMIA
AGOTAMIENTO CÉLULA β
INSUFICIENCIA RENAL
SEGURIDAD EN IC ?

10-Year Follow-up of Intensive Glucose Control in Type 2 Diabetes

Rury R. Holman, F.R.C.P., Sanjoy K. Paul, Ph.D., M. Angelyn Bethel, M.D., David R. Matthews, F.R.C.P., and H. Andrew W. Neil, F.R.C.P.

N Engl J Med 2008;359:1577-89.

-Disminución eventos CV en el grupo de tto intensivo incluido los tratados con SU
-No datos de más casos de IC

The Prospective Pioglitazone Clinical Trial in Macrovascular Events (PROactive)

Can pioglitazone reduce cardiovascular events in diabetes? Study design and baseline characteristics of 5,238 patients

n	5,238
Demographic data	
Age (years)	61.8 ± 7.7
Male	3,463 (66.1)
Caucasian	5,162 (98.5)
Duration of type 2 diabetes (years)	9.5 ± 7.0

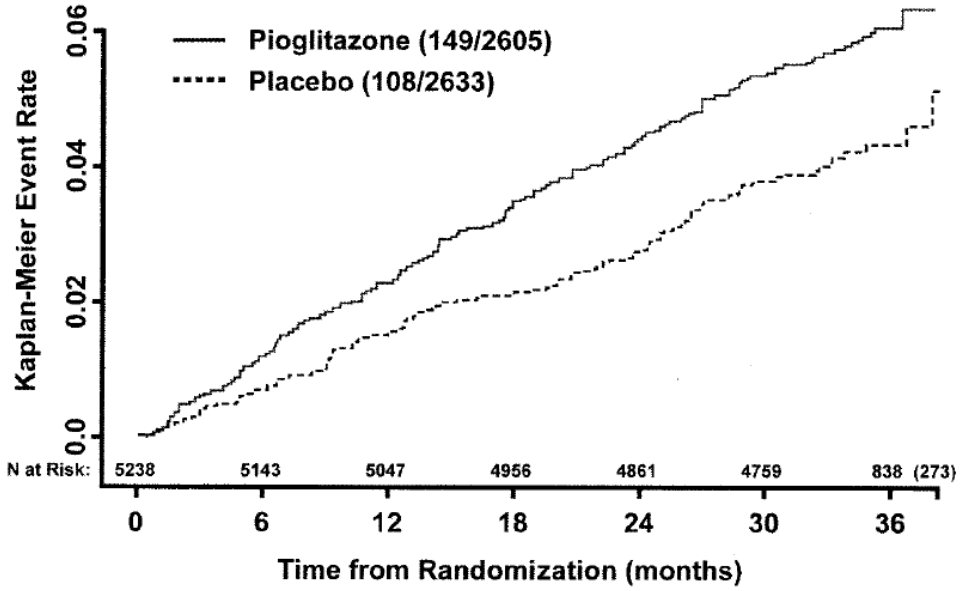
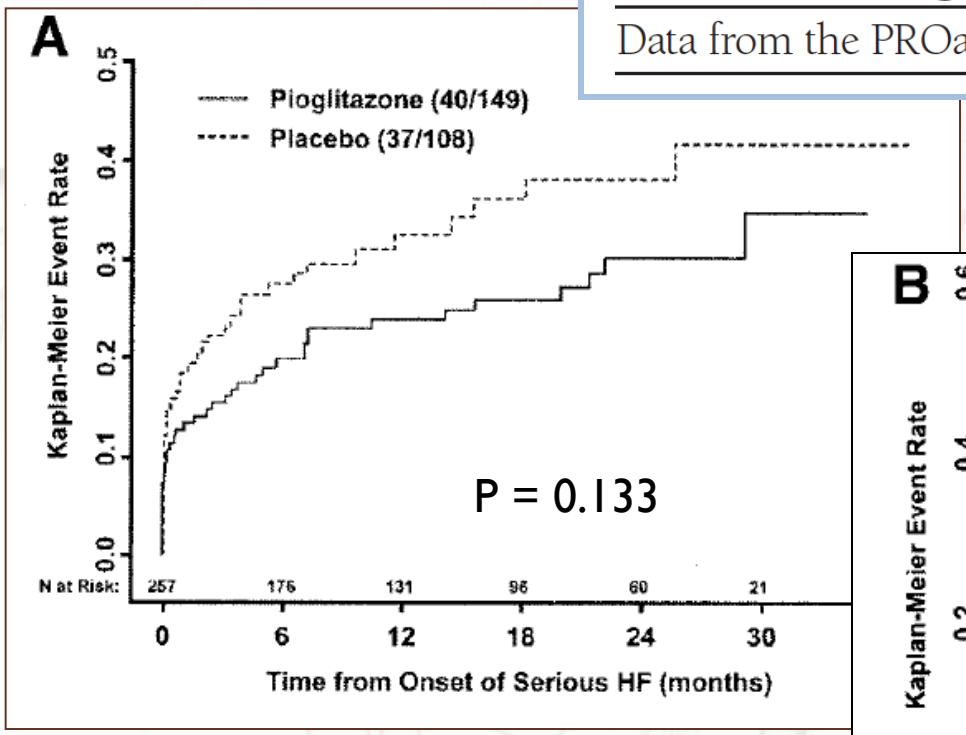


Figure 1—*Kaplan-Meier estimates of time to serious heart failure.*

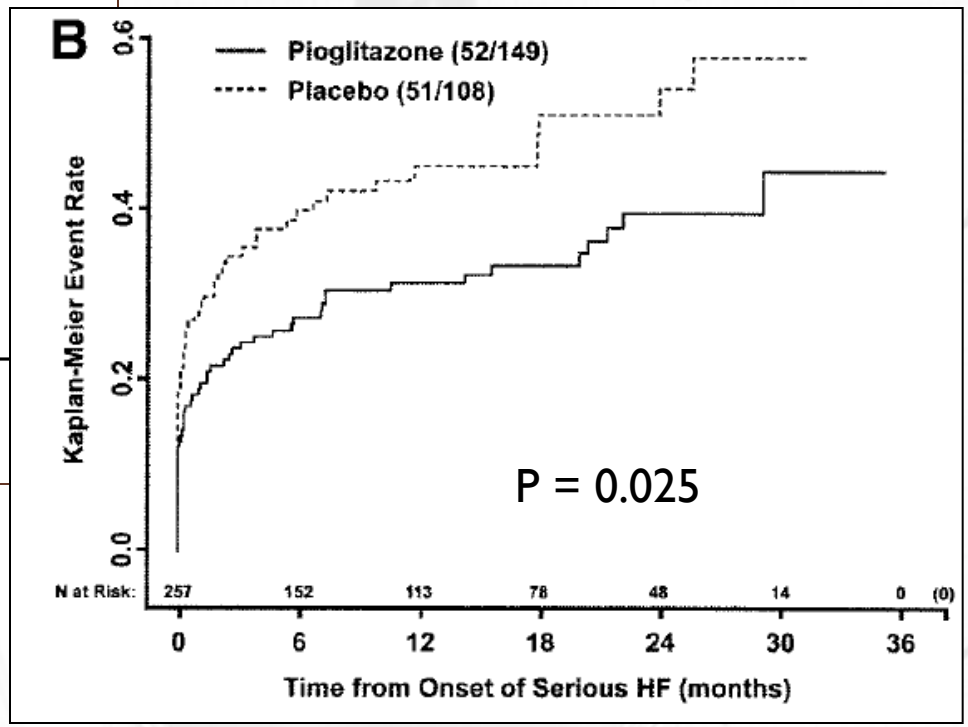
Diabetes Care 2007; 30: 2773-78

Pioglitazone Use and Heart Failure in Patients With Type 2 Diabetes and Preexisting Cardiovascular Disease

Data from the PROactive Study (PROactive 08)



Mortalidad Total



Eventos Combinados

Diabetes Care 30:2773–2778, 2007

Clinical Trials

Pioglitazone and Heart Failure: Results From a Controlled Study in Patients With Type 2 Diabetes Mellitus and Systolic Dysfunction

Table 2. Incidence of Primary End Point and Contributing Events (ITT Analysis)

	Pioglitazone (n = 262)	Glyburide (n = 256)	P value
Composite event n (%)	35 (13.4)	21 (8.2)	.024
Death from CV cause	5 (1.9)	6 (2.3)	
Overnight hospitalization for worsening CHF	26 (9.9)	12 (4.7)	
ER visit for CHF	4 (1.5)	3 (1.2)	

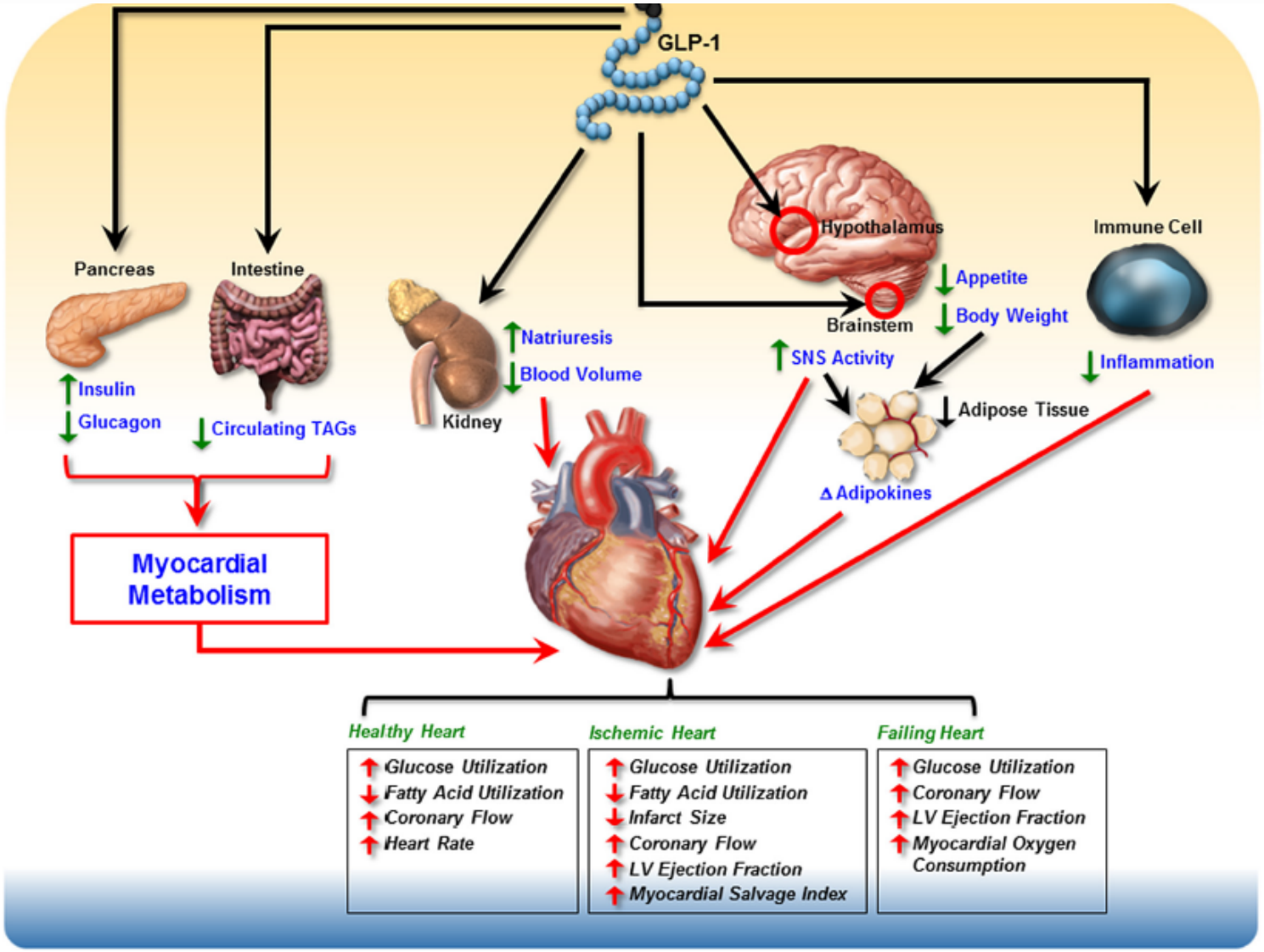
Pioglitazone (n = 262)	Glyburide (n = 256)
64.2 (9.92)	63.4 (9.38)

Giles et al. J Cardiac Fail 2008; 14: 445-52

INHIBIDORES SGLT2

No disponemos de DATOS:

- > 65 AÑOS ; > 75 años
- DEPLECIÓN DE VOLUMEN
- NO USAR CON DIURETICOS DE ASA
- CONOCIMIENTO LIMITADO EN IC CLASE I-II
- DESCONOCIMIENTO EN CLASE III-IV



Circ Res. 2014; 114:1788-1803

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Saxagliptin and Cardiovascular Outcomes in Patients with Type 2 Diabetes Mellitus

N Engl J Med 2013;369:1317-26.
DOI: 10.1056/NEJMoa1307684

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

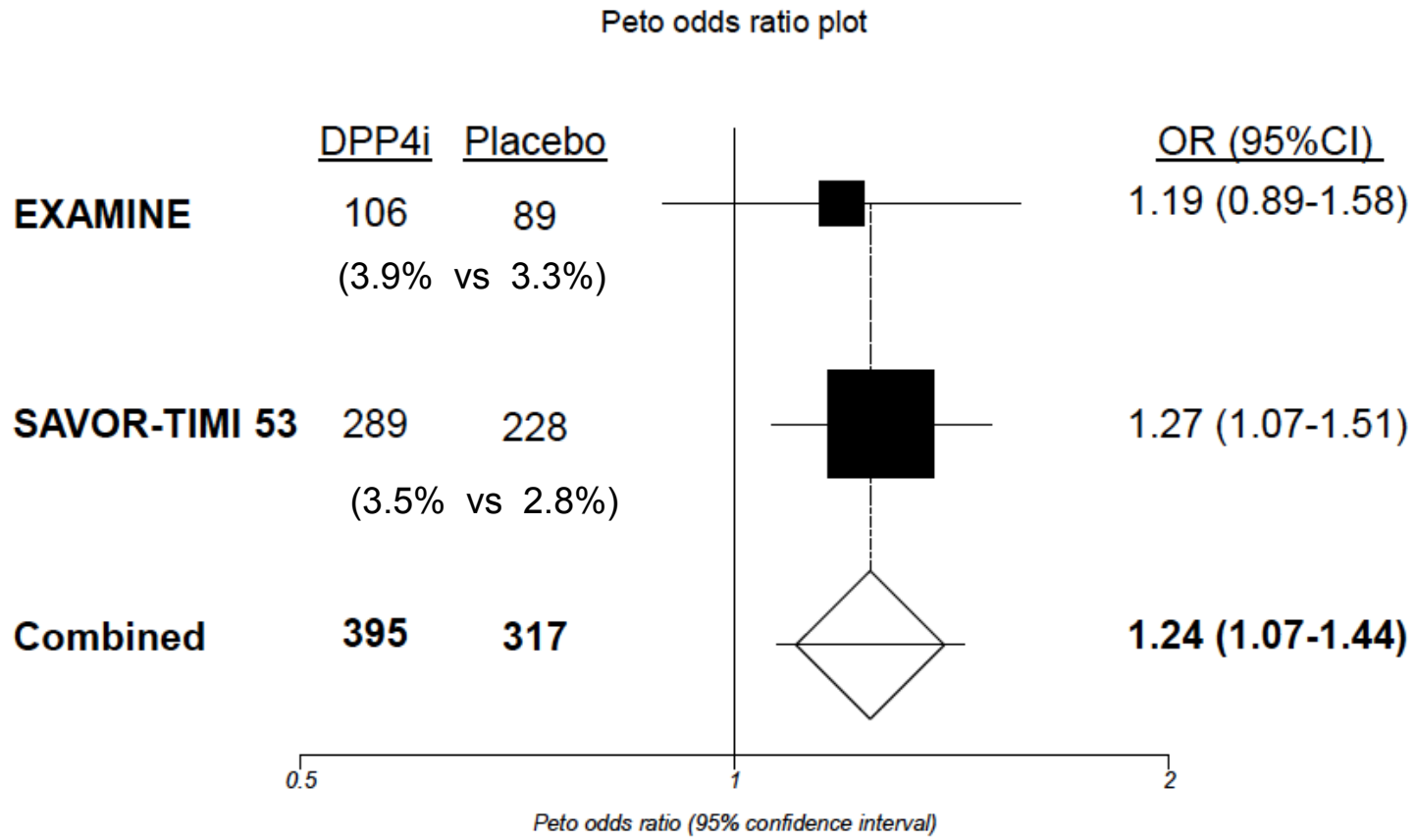
Alogliptin after Acute Coronary Syndrome in Patients with Type 2 Diabetes

N Engl J Med 2013;369:1327-35.
DOI: 10.1056/NEJMoa1305889

Table 2. Prespecified Clinical End Points.*

End Point	Saxagliptin (N=8280)	Placebo (N=8212)	Hazard Ratio (95% CI)	P Value
	no. (%)			
Cardiovascular death, myocardial infarction, or stroke: primary efficacy end point	613 (7.3)	609 (7.2)	1.00 (0.89–1.12)	0.99
Cardiovascular death, myocardial infarction, stroke, hospitalization for unstable angina, heart failure, or coronary revascularization: secondary efficacy end point	1059 (12.8)	1034 (12.4)	1.02 (0.94–1.11)	0.66
Death from any cause	420 (4.9)	378 (4.2)	1.11 (0.96–1.27)	0.15
Death from cardiovascular causes	269 (3.2)	260 (2.9)	1.03 (0.87–1.22)	0.72
Myocardial infarction	265 (3.2)	278 (3.4)	0.95 (0.80–1.12)	0.52
Ischemic stroke	157 (1.9)	141 (1.7)	1.11 (0.88–1.39)	0.38
Hospitalization for unstable angina	97 (1.2)	81 (1.0)	1.19 (0.89–1.60)	0.24
Hospitalization for heart failure	289 (3.5)	228 (2.8)	1.27 (1.07–1.51)	0.007
Hospitalization for coronary revascularization	423 (5.2)	459 (5.6)	0.91 (0.80–1.04)	0.18
Doubling of creatinine level, initiation of dialysis, renal transplantation, or creatinine >6.0 mg/dl (530 μmol/liter)	194 (2.2)	178 (2.0)	1.08 (0.88–1.32)	0.46
Hospitalization for hypoglycemia	53 (0.6)	43 (0.5)	1.22 (0.82–1.83)	0.33

N Engl J Med 2013;369:1317-26.



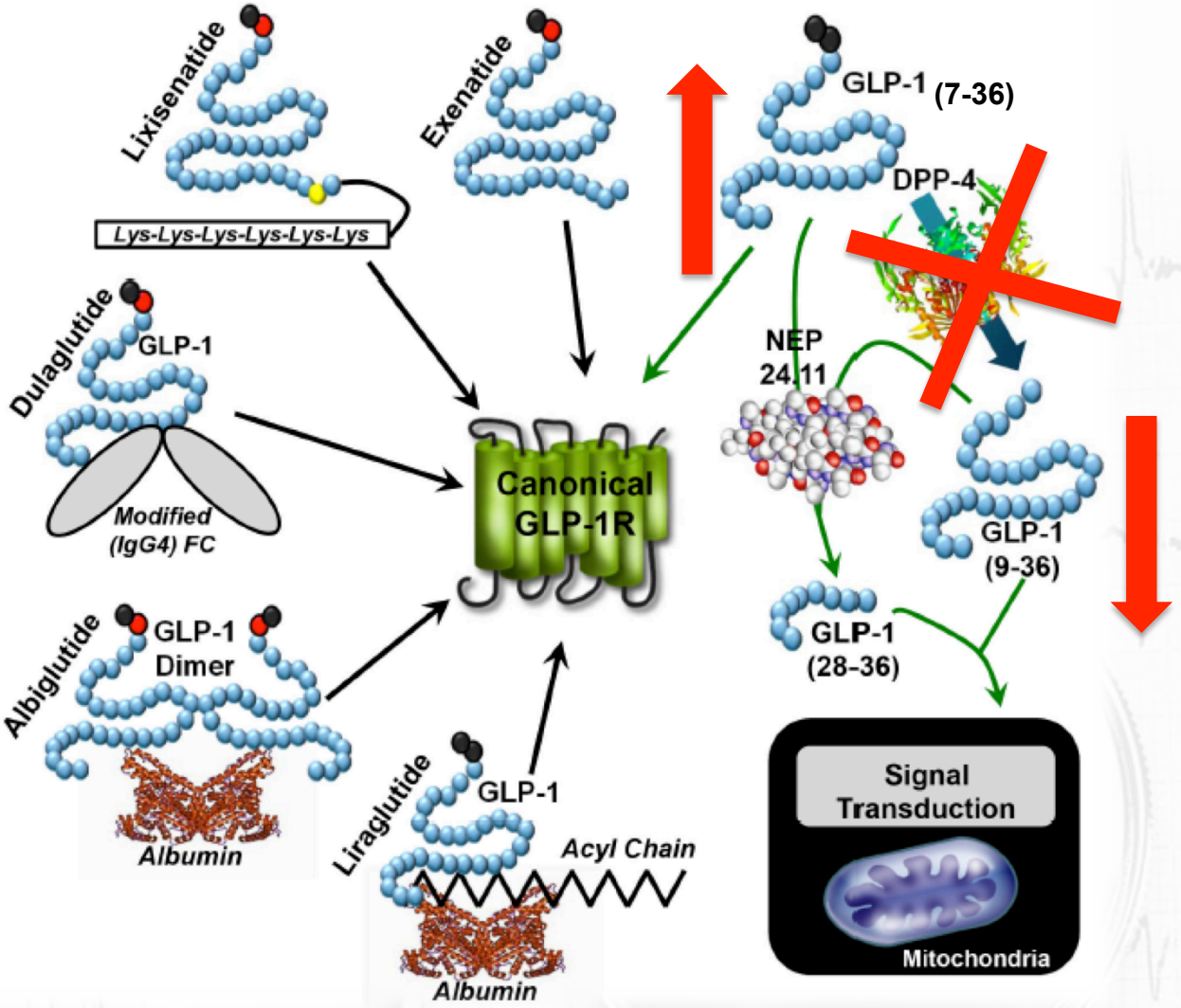
Circulation 2014; 130:1579-1588

	N	Chi-Square	Adjusted Hazard Ratio	95% Confidence Intervals		P values
NT-proBNP > 332 pg/ml (Quartile 4)	2949	161.9	5.47	4.21	7.10	<0.01
Prior Heart Failure	1537	99.0	2.98	2.40	3.69	<0.01
Albumin/creatinine ratio > 33.9 mg/mmol	1211	38.1	2.35	1.79	3.08	<0.01
eGFR ≤60 ml/min	3237	14.5	1.43	1.12	1.83	<0.01
Non-Hispanic	3463	14.0	1.54	1.23	1.92	<0.01
Albumin/creatinine ratio 3.4 - ≤ 33.9 mg/mmol	9129	8.2	1.80	1.32	2.45	<0.01
Saxagliptin	5915	6.4	1.30	1.06	1.60	0.01
Prior MI	4562	4.8	1.28	1.03	1.60	0.03
Female	3949	4.3	0.78	0.62	0.99	0.04
Age ≥ 75 years	1630	2.7	1.23	0.96	1.57	0.10
Dyslipidemia	8403	1.7	1.18	0.92	1.51	0.19
Established CV disease	9210	0.7	1.17	0.82	1.68	0.39

Circulation 2014; 130:1579-1588

Table 2. Multivariable Analysis Evaluating the Relationship between Baseline Clinical Characteristics and Risk for Hospitalization for Heart Failure in the overall SAVOR-TIMI 53 population.

	N	Chi-Square	Adjusted Hazard Ratio	95% Confidence Intervals		P values
Prior Heart Failure	1986	231.99	4.18	3.48	5.02	<0.01
Albumin/creatinine ratio > 33.9 mg/mmol	1,638	119.26	3.66	2.90	4.62	<0.01
Albumin/creatinine ratio 3.4 - ≤ 33.9 mg/mmol	4,426	35.77	1.89	1.54	2.34	<0.01
eGFR ≤60 ml/min	4602	49.86	2.00	1.65	2.42	<0.01
Age ≥ 75 years	2192	24.92	1.70	1.38	2.09	<0.01
Prior MI	5933	15.62	1.47	1.21	1.78	<0.01
Non-hispanic	12327	10.71	1.56	1.20	2.04	<0.01
Established CV disease	12344	8.81	1.64	1.18	2.28	<0.01
Saxagliptin	7916	7.77	1.29	1.08	1.54	0.01
Female	5205	6.93	0.76	0.62	0.93	0.01
Dyslipidemia	11213	4.63	1.27	1.02	1.59	0.03



Circ Res. 2014; 114:1788-1803

Table. Contrasting Actions of Native GLP-1, GLP-1R Agonists, DPP-4 Inhibitors, and GLP-1(9–36) on the Cardiovascular System and Cardiovascular Risk Factors

	GLP-1R Agonists	GLP-1	DPP-4 Inhibitors	GLP-1(9–36)
LV function	Increased	Increased	Increased	Increased
Heart rate	Increased	Increased	No effect	No effect
Coronary flow	No effect	Increased	No effect	Increased
Infarct size	Decreased	Decreased	Decreased	Decreased
Body weight	Decreased	Decreased	No effect	No effect
Blood pressure	Decreased	Decreased	No effect/decreased	ND

The table depicts the effects of native GLP-1, GLP-1R agonists, GLP-1(9–36), and DPP-4 inhibitors on the parameters important for the cardiovascular system as inferred from available preclinical and limited clinical studies. Scant data from head-to-head clinical trials using these agents limit extrapolation of the available data to human subjects. DPP-4 indicates dipeptidyl peptidase-4; GLP-1R, glucagon-like peptide-1 (GLP-1) receptor; LV, left ventricular; and ND, not determined.

Circ Res. 2014; 114:1788-1803

XVII Reunión
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RESULTADO GLOBAL
OR 1.19 (1.03-1.37)
p=0.015

Nutrition, Metabolism & Cardiovascular Diseases (2014) 24, 689–697

Available online at www.sciencedirect.com

Nutrition, Metabolism & Cardiovascular Diseases

journal homepage: www.elsevier.com/locate/nmcd

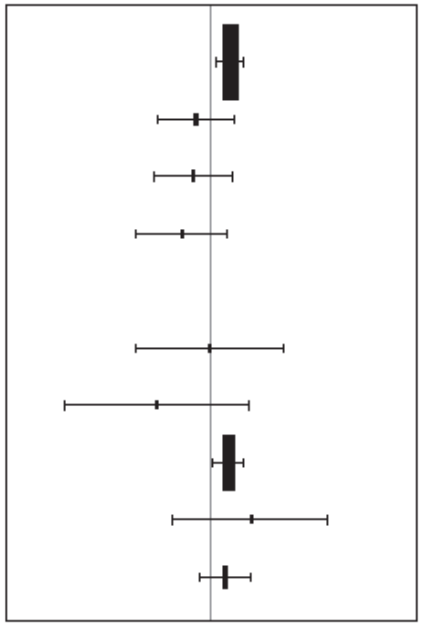
META-ANALYSIS

Dipeptidyl peptidase-4 inhibitors and heart failure: A meta-analysis of randomized clinical trials

M. Monami [a], I. Dicembrini [b,c], E. Mannucci [c,*]

Subgrupos

	N trials	DPP4i	Comparator	MH-OR	LL	UL	p
		Heart failure (n events)					
SAVOR+EXAMINE	2	395	317	1.24	1.07	1.45	0.004
Trials with non-CV end.	35	53	44	0.85	0.56	1.29	0.45
Excluding trials vs TZDs	33	52	41	0.83	0.54	1.28	0.41
Excluding trials vs TZDs/SUs	26	36	18	0.73	0.44	1.20	0.22
vs other comparators							
Sitagliptin	11	14	15	0.99	0.44	2.24	0.980
Vildagliptin	6	6	10	0.55	0.20	1.53	0.25
Saxagliptin	10	300	237	1.22	1.03	1.45	0.024
Linagliptin	5	16	8	1.56	0.66	3.65	0.310
Alogliptin	5	112	91	1.18	0.89	1.56	0.250



JACC: HEART FAILURE

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Sitagliptin Use in Patients With Diabetes and Heart Failure

A Population-Based Retrospective Cohort Study

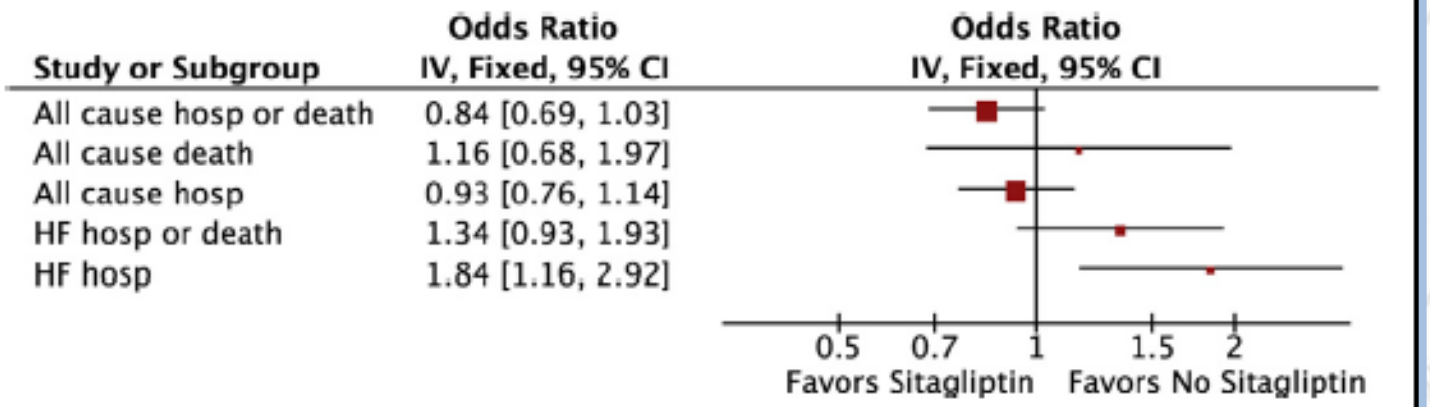


FIGURE 3 Forest Plot of Primary and Secondary Endpoints According to Sitagliptin Use

Primary and secondary endpoints after incident HF were evaluated acc
use versus nonuse 90 days before each outcome. CI = confidence inte
failure; hosp = hospitalization; IV = interval.

Control (n = 41,297)	Case (n = 4,137)	p Value*
54.6 ± 8.7	54.6 ± 8.7	0.97

JACC Heart Fail 2014; 2: 573-82

No asociación a la MORTALIDAD

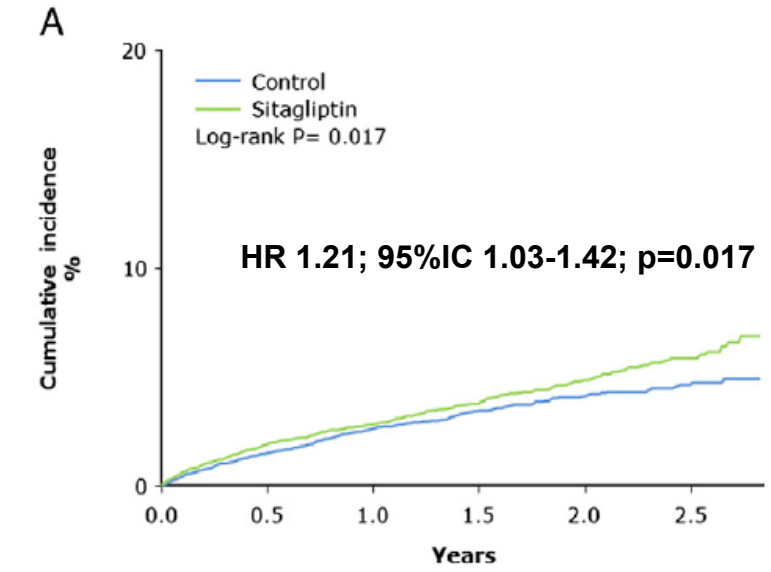
International Journal of Cardiology 177 (2014) 86–90

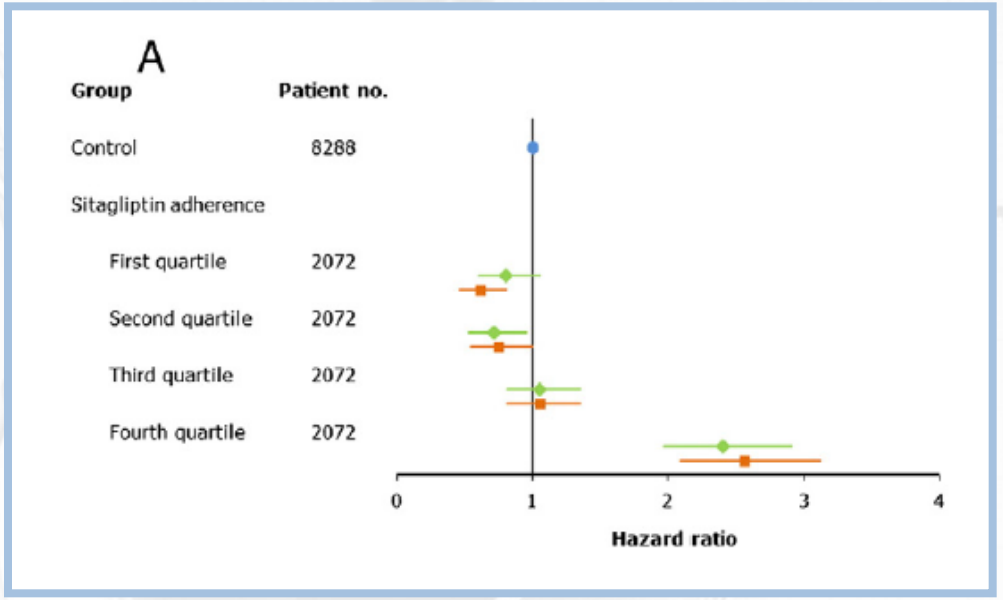
Contents lists available at ScienceDirect

International Journal of Cardiology

journal homepage: www.elsevier.com/locate/ijcard

Sitagliptin and the risk of hospitalization for heart failure: A population-based study☆





Baseline characteristics of the patients.

Characteristic	Control (N = 8288)	Sitagliptin (N = 8288)	P value
Age, year	64.3 ± 9.9	64.4 ± 10.4	0.864

Diabetes Care Volume 38, February 2015

Incretin-Based Drugs and the Risk of Congestive Heart Failure

Diabetes Care 2015;38:277–284 | DOI: 10.2337/dc14-1459

Table 3—Crude and adjusted ORs of hospitalization for CHF, comparing incretin-based drugs to combinations of oral antidiabetic drugs[a]

Current exposure[b]	Case subjects (*n* = 1,118)	Control subjects (*n* = 17,626)	Crude OR (95% CI)	Adjusted OR[c] (95% CI)
≥2 oral antidiabetic drugs, *n* (%)	267 (23.9)	4,198 (23.8)	1.00 (Reference)	1.00 (Reference)
Incretin-based drugs, *n* (%)	64 (5.7)	923 (5.2)	0.98 (0.73–1.33)	0.85 (0.62–1.16)
DPP-4 inhibitors	54 (4.8)	808 (4.6)	0.96 (0.70–1.32)	0.88 (0.63–1.22)
GLP-1 analogs	10 (0.9)	115 (0.7)	1.18 (0.59–2.39)	0.67 (0.32–1.42)
Duration of incretin-based drug use,[d] *n* (%)				
1–83 days	25 (2.2)	310 (1.8)	1.18 (0.74–1.89)	1.01 (0.62–1.63)
84–265 days	18 (1.6)	299 (1.7)	0.86 (0.51–1.44)	0.79 (0.46–1.36)
>265 days	21 (1.9)	314 (1.8)	0.92 (0.56–1.50)	0.75 (0.45–1.25)
				P trend = 0.39

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Trial record **1 of 1** for: NCT01243424
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CAROLINA: Cardiovascular Outcome Study of Linagliptin Versus Glimepiride in Patients With Type 2 Diabetes

This study is ongoing, but not recruiting participants.

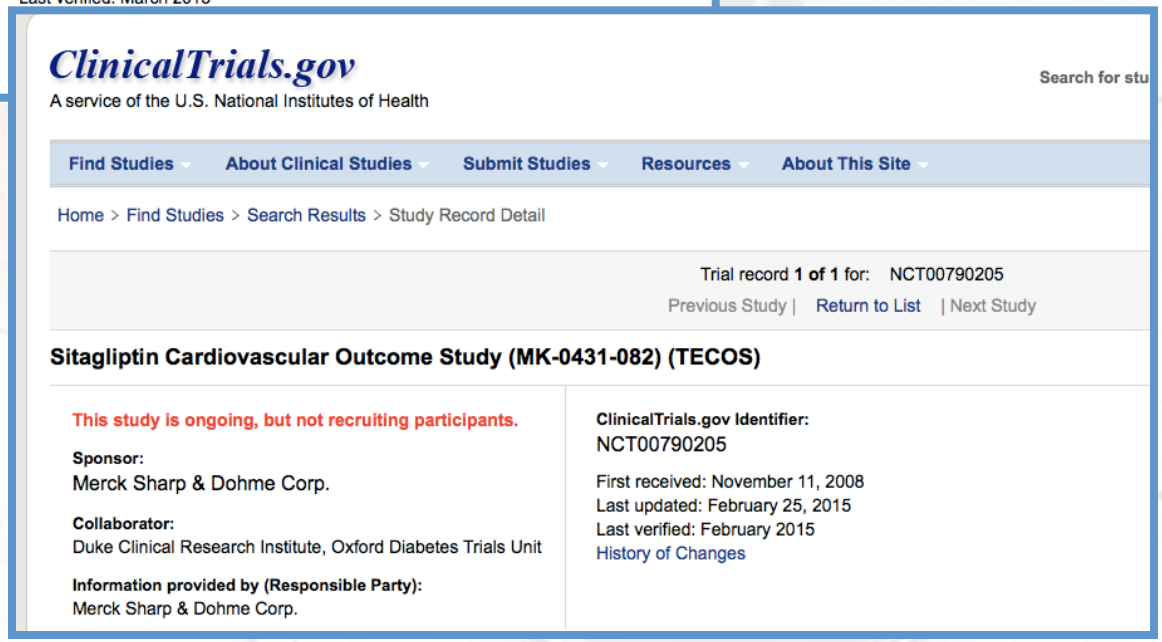
Sponsor:
Boehringer Ingelheim

Collaborator:
Eli Lilly and Company

Information provided by (Responsible Party):
Boehringer Ingelheim

ClinicalTrials.gov Identifier:
NCT01243424

First received: November 17, 2010
Last updated: March 17, 2015
Last verified: March 2015



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Sitagliptin Cardiovascular Outcome Study (MK-0431-082) (TECOS)

This study is ongoing, but not recruiting participants.

Sponsor:
Merck Sharp & Dohme Corp.

Collaborator:
Duke Clinical Research Institute, Oxford Diabetes Trials Unit

Information provided by (Responsible Party):
Merck Sharp & Dohme Corp.

ClinicalTrials.gov Identifier:
NCT00790205

First received: November 11, 2008
Last updated: February 25, 2015
Last verified: February 2015
History of Changes

BMJ open
accessible medical research

Effects of exenatide and liraglutide on heart rate, blood pressure and body weight: systematic review and meta-analysis

Louise E Robinson,[1] Tim A Holt,[1,2] Karen Rees,[1] Harpal S Randeva,[1]
h P O'Hare[1]

BMJ Open 2013;**3**:e001986. doi:10.1136/bmjopen-2012-001986

Studies included in review
(n =32)

- Heart rate rises were more evident for liraglutide than exenatide, and for exenatide long-acting release than exenatide twice daily.

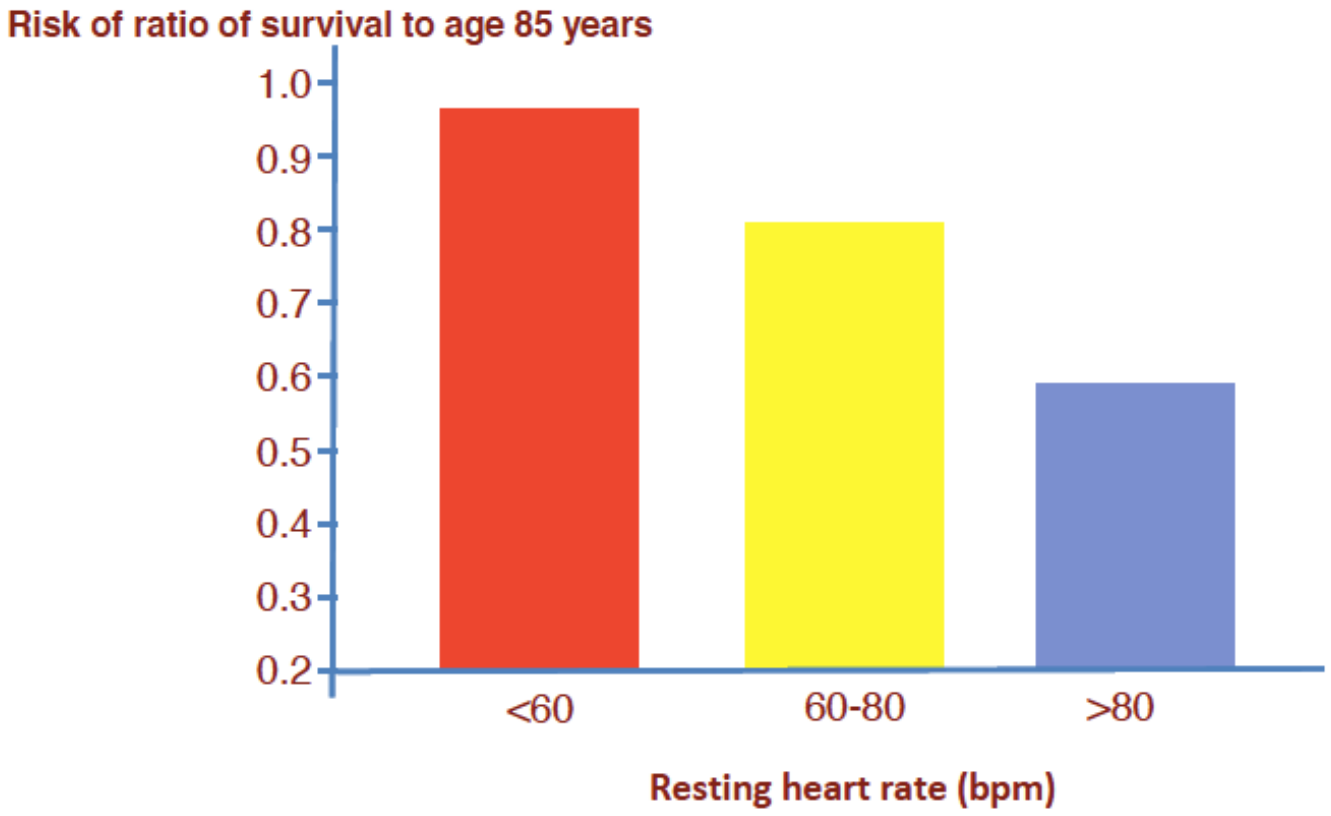
- La **frecuencia cardiaca** se midió en decúbito supino a las 24h tras la última administración del estudio (día 29)
  - Con *lixisenatida disminuyó 3,6 lpm* frente a un *aumento de 5,3 lpm con liraglutida*, con una **diferencia neta de 8,9 lpm que fue estadísticamente significativa**.

	Lixisenatide (n = 77)	Liraglutide (n = 71)
Vital sign measurements		
Δ heart rate, bpm [mean (95% CI)]†	−3.6 (−5.8, −1.3)	5.3 (2.9, 7.7)
Treatment difference, mmHg (95% CI)	−8.9 (−12.2, −5.6)	
Δ ECG heart rate, bpm [mean (95% CI)]†	−3.4 (−5.6, −1.2)	5.9 (3.6, 8.2)
Treatment difference, mmHg (95% CI)	−9.3 (−12.5, −6.1)	
Δ SBP, mmHg [mean (95% CI)]†	−2.0 (−4.9, 0.8)	−2.8 (−5.9, 0.2)
Treatment difference, mmHg (95% CI)	0.8 (−3.3, 5.0)	
Δ DBP, mmHg [mean (95% CI)]†	−0.6 (−2.2, 1.1)	1.1 (−0.7, 2.8)
Treatment difference, mmHg (95% CI)	−1.7 (−4.1, 0.7)	

Diabetes, Obesity and Metabolism 15: 642–649, 2013.

Frecuencia Cardiaca en reposo predice supervivencia en > 65 años

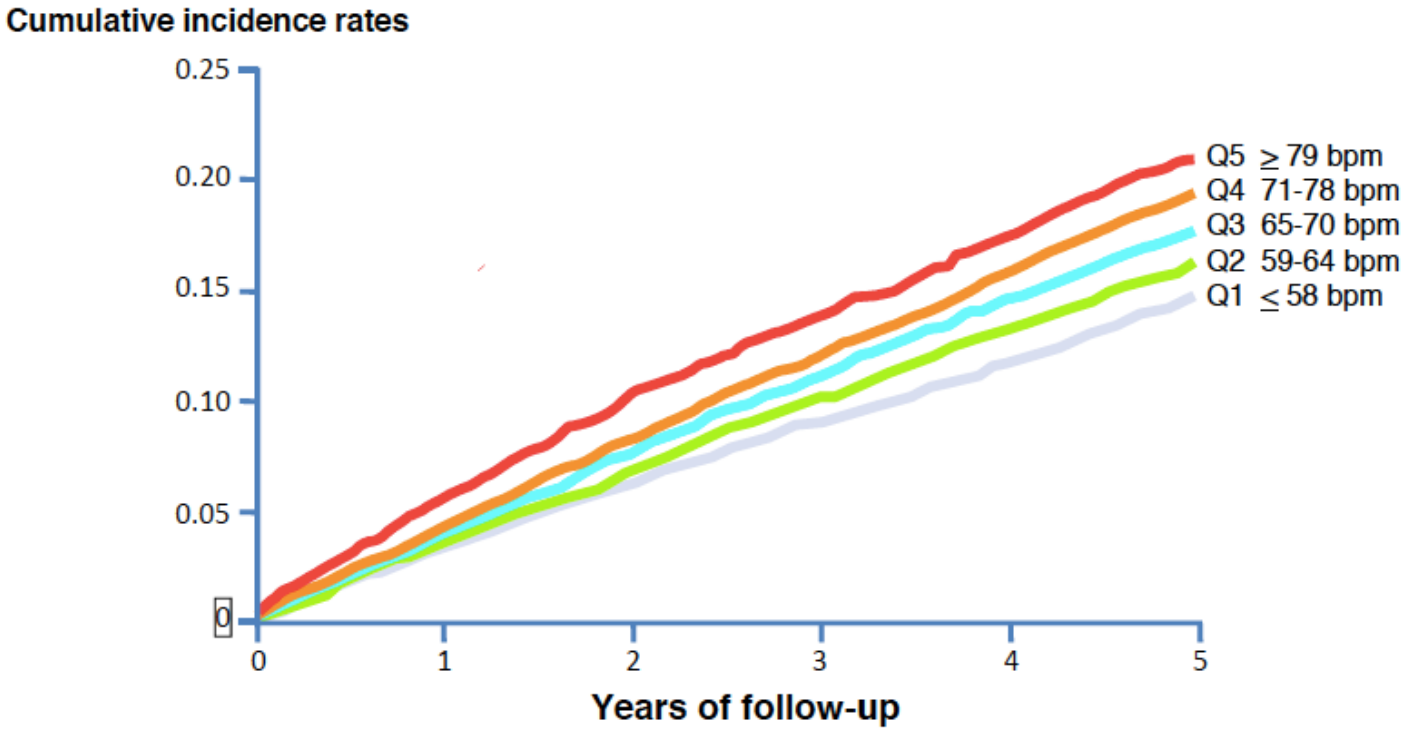
The Cohort study (n=1407)



Benetos A, et al. *J Am Geriatr Soc*. 2003;51:284-285.

La FC se asocia con un aumento del riesgo de eventos CV en diabéticos con Enf. Coronaria Estable

The ONTARGET/TRANSCEND trial (n=31531)

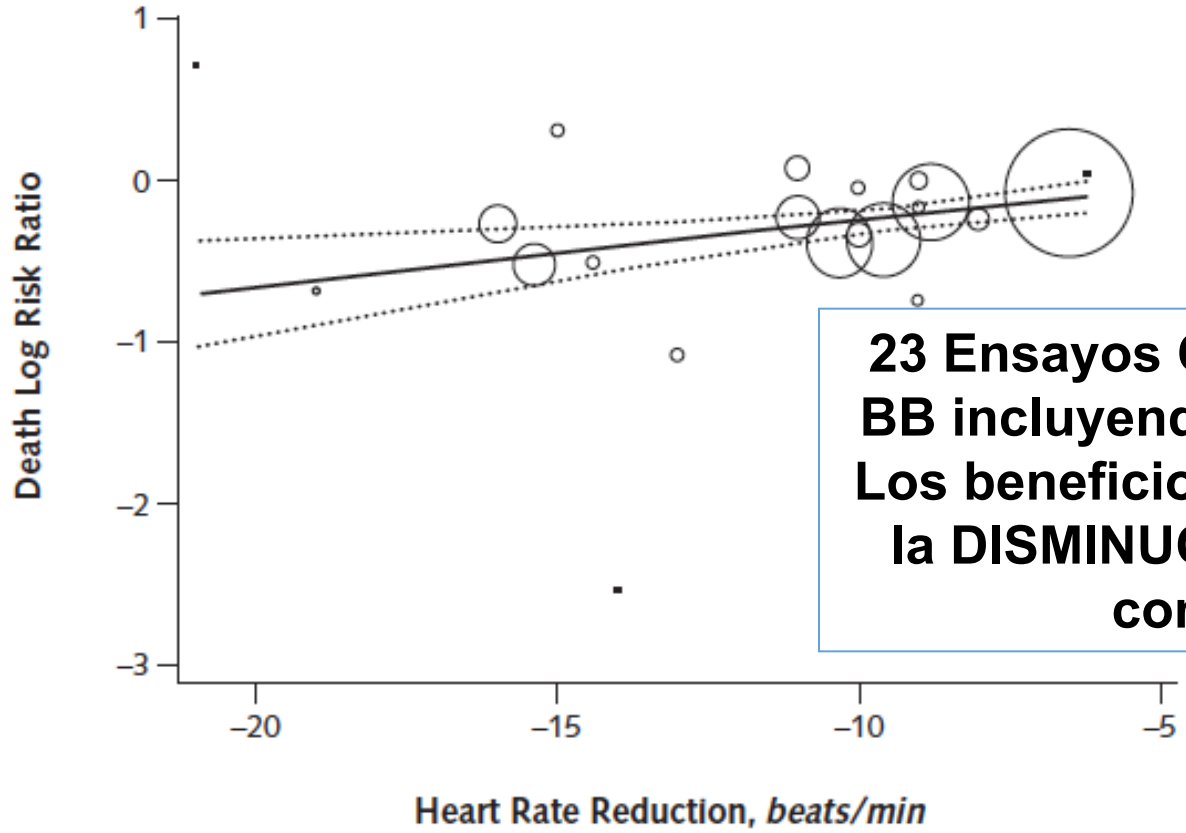


Rambihar S, et al. *Circulation*. 2010;122(suppl. 21): abstract12667

REVIEW | Annals of Internal Medicine

Meta-analysis: β-Blocker Dose, Heart Rate Reduction, and Death in Patients With Heart Failure

Ann Intern Med. 2009;150:784-794.



23 Ensayos Clínicos en ICC con BB incluyendo 19.209 pacientes. Los beneficios se relacionan con la DISMINUCIÓN de la FC y no con la dosis.

Por CADA 5 LATIDOS DISMINUYE LA MORTALIDAD 18%

Sanofi Announces Top-Line Results for Cardiovascular Outcomes Study of Lyxumia® (lixisenatide)

- Results support resubmission of U.S. New Drug Application in Q3 2015 -

Paris, France – March 19, 2015 - Sanofi announced today top-line results of the Phase IIIb ELIXA cardiovascular outcomes study, which compared lixisenatide to placebo in a high-risk population of adults with type 2 diabetes evaluating cardiovascular safety. The study showed that lixisenatide was non-inferior, although not superior, to placebo for cardiovascular safety.

Liraglutide Effect and Action in Diabetes: Evaluation of Cardiovascular Outcome Results - A Long Term Evaluation (LEADER®)

This study is ongoing, but not recruiting participants.

Sponsor:
Novo Nordisk A/S

Information provided by (Responsible Party):
Novo Nordisk A/S

ClinicalTrials.gov Identifier:
NCT01179048

First received: August 6, 2010
Last updated: January 7, 2015
Last verified: January 2015
History of Changes

Recruiting — **Exenatide Study of Cardiovascular Event Lowering Trial (EXSCEL): A Trial To Evaluate Cardiovascular Outcomes After Treatment With Exenatide Once Weekly In Patients With Type 2 Diabetes Mellitus**

Condition: Type 2 Diabetes Mellitus

Interventions: Drug: Exenatide Once Weekly; Drug: Placebo

Active, not recruiting — **Researching Cardiovascular Events With a Weekly Incretin in Diabetes (REWIND)**

Conditions: Cardiovascular Disease; Diabetes Mellitus, Type 2

Interventions: Drug: Dulaglutide; Drug: Placebo

Insulina Basal

Outcome	Insulin Glargine (N=6264)		Standard Care (N=6273)		Hazard Ratio (95% CI)	P Value
	no. (%)	no./100 patient-yr	no. (%)	no./100 patient-yr		
First coprimary outcome	1041 (16.6)	2.94	1013 (16.1)	2.85	1.02 (0.94–1.11)	0.63
Second coprimary outcome	1792 (28.6)	5.52	1727 (27.5)	5.28	1.04 (0.97–1.11)	0.27
Microvascular outcomes	1323 (21.1)	3.87	1363 (21.7)	3.99	0.97 (0.90–1.05)	0.43
Total mortality	951 (15.2)	2.57	965 (15.4)	2.60	0.98 (0.90–1.08)	0.70
Total myocardial infarctions	336 (5.4)	0.93	326 (5.2)	0.90	1.02 (0.88–1.19)	0.75
Total strokes	331 (5.3)	0.91	319 (5.1)	0.88	1.03 (0.89–1.21)	0.69
Death from cardiovascular causes	580 (9.3)	1.57	576 (9.2)	1.55	1.00 (0.89–1.13)	0.98
Hospitalization for congestive heart failure	310 (4.9)	0.85	343 (5.5)	0.95	0.90 (0.77–1.05)	0.16
Revascularization	908 (14.5)	2.69	860 (13.7)	2.52	1.06 (0.96–1.16)	0.24
Angina	709 (11.3)	2.07	743 (11.8)	2.17	0.95 (0.85–1.05)	0.29
Unstable	238 (3.8)	0.66	261 (4.2)	0.72	0.91 (0.76–1.08)	0.28
New	100 (1.6)	0.27	138 (2.2)	0.38	0.72 (0.56–0.93)	0.01
Worsening	455 (7.3)	1.29	446 (7.1)	1.26	1.02 (0.89–1.16)	0.80
Limb or digit amputation	47 (0.8)	0.13	53 (0.8)	0.14	0.89 (0.60–1.31)	0.55
Cardiovascular hospitalization	2081 (33.2)	6.98	2071 (33.0)	6.91	1.00 (0.94–1.07)	0.90
Noncardiovascular hospitalization	2339 (37.3)	7.90	2349 (37.4)	7.93	0.99 (0.94–1.05)	0.85
Any cancer	476 (7.6)	1.32	477 (7.6)	1.32	1.00 (0.88–1.13)	0.97
Death from cancer	189 (3.0)	0.51	201 (3.2)	0.54	0.94 (0.77–1.15)	0.52

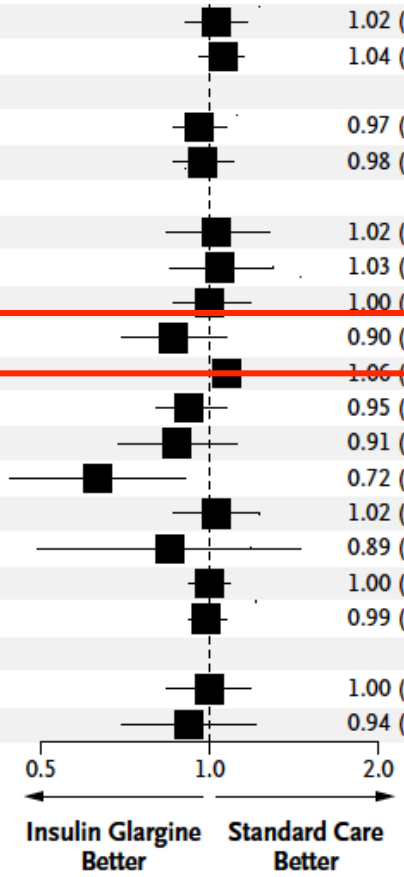
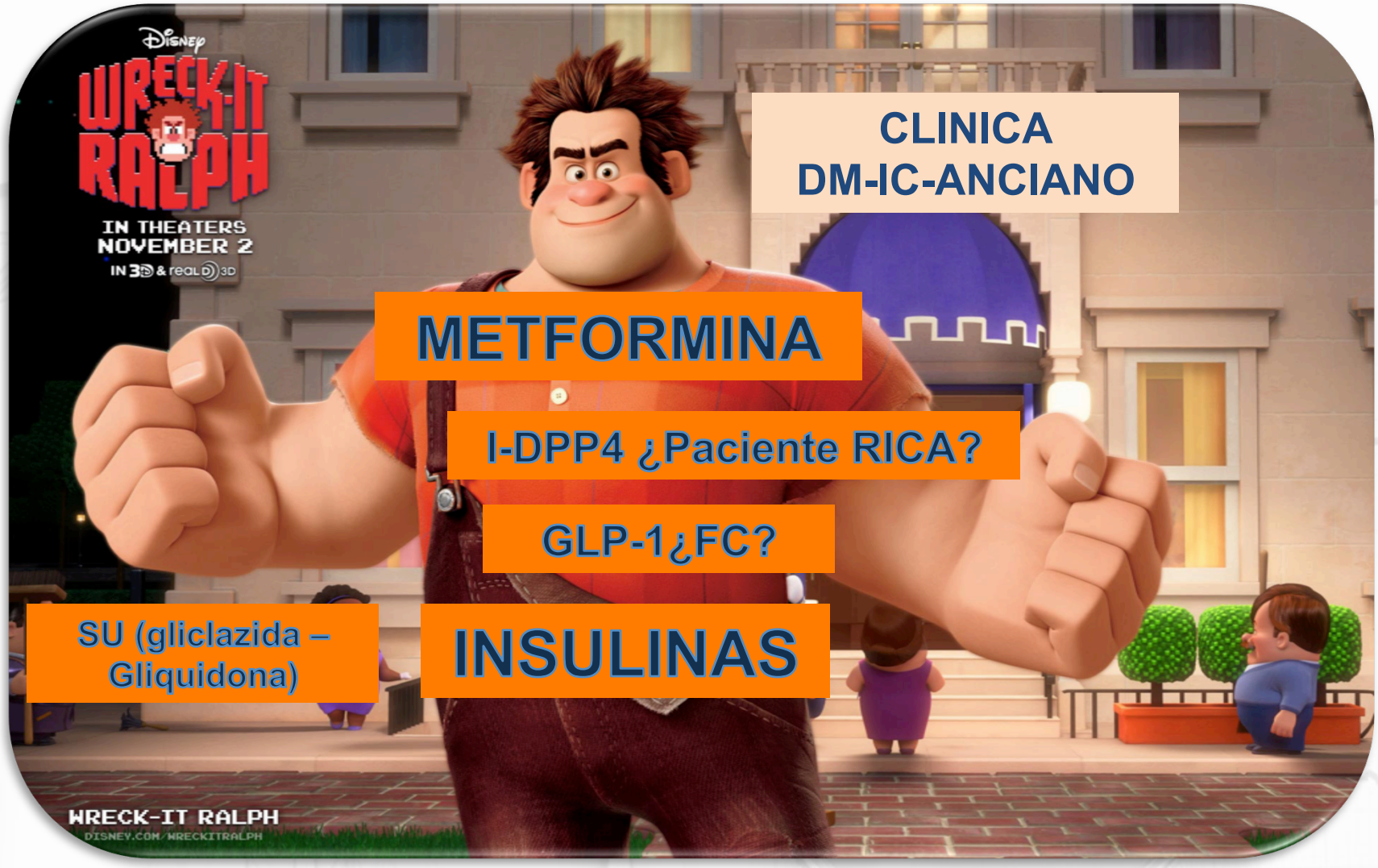


Figure 1. Hazard Ratios for the Coprimary and Other Outcomes.

N Engl J Med 2012;367:319-28.
DOI: 10.1056/NEJMoa1203858

MENSAJES BÁSICOS

- ARTE MÉDICO del INTERNISTA
- INDIVIDUALIZAR con MAYÚSCULAS
  - Plantear OBJETIVOS de control
  - Disminuir Riesgo de Hipoglucemia
- Evaluar SIEMPRE la Función Renal
- Elección muy SABIA:
  - METFORMINA mejor perfil
  - SU limitadas por hipoglucemia e I. Renal
  - No se recomienda la Pioglitazona
  - iDPP-4 ¿Cuidado en el Paciente RICA?
  - GLP-1 Vigilar la frecuencia cardiaca
  - Insulina Muy buen perfil de seguridad controlando la hipoglucemia



CLINICA
DM-IC-ANCIANO

METFORMINA

I-DPP4 ¿Paciente RICA?

GLP-1¿FC?

SU (gliclazida – Gliquidona)

INSULINAS