ADA Primary Care Updates 2025

2/27/25

Jonathan Gabison, MD

Two Steps to Receive CME/CE Credit

STEP 1:

Scan me to open a text message!

Text in CE Code 83257 to 833-256-8390

by 1:00 PM on February 28th

This activates your online evaluation in the CE portal (new users follow prompts after texting to set up account).

STEP 2:

Complete the required online evaluation

by March 13, 2025

In the Cloud CME portal at **https://beaumont.cloud-cme.com** [Sign In > select **My CME** > select **Evaluations & Certificates**] – or – via the free CloudCME mobile app (organization code *Beaumont)*

Refer to full CE document for additional CE information. For assistance, email **CHEcme@corewellhealth.org**

Disclosure of Financial Relationships:

The following speakers and/or planning committee members have identified the following relevant financial relationship(s) with ineligible companies.

All other individuals involved with this activity have no relevant financial relationships with ineligible companies to disclose.

- **Jonathan Gabison, M.D.:** Consultant-Eli Lilly.
- **Lauren Oshman, M.D.** (Course Co-Director): Stocks in publicly traded companies or stock options, excluding diversified mutual funds-Abbott, AbbVie, Johnson & Johnson, Merck & Co., Organon.

MCT2D Learning Community Series 2025
ADA Standards of Care 2025 Updates

CME/CE credit is available

In support of improving patient care, this activity has been planned and implemented by Corewell Health Southeast Michigan and Michigan Collaborative for Type 2 Diabetes. Corewell Health Southeast Michigan is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

This activity was planned by and for the healthcare team, and learners will receive 1.0 Interprofessional Continuing Education (IPCE) credit for learning and change.

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Dietetic CPEU:

Commission on Dietetic Registration
the credentialing agency for the Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

If the activity is dietetics-related but not targeted to RDs or DTRs, CPEUs may be claimed which are commensurate with participation in contact hours (One 60 minute hour = 1 CPEU).

RD's and DTRs are to select activity type 102 in their Activity Log. Sphere and Competency selection is at the learner's discretion.

Sign In Procedure

Please use the link that will be sent to your email to sign in!

This Sign-In Sheet is used to track your attendance. **This only applies to physicians within MCT2D who want to earn learning community credit for their attendance. If you are not a physician, you do not need to sign in.** Correctly signing in on the Sign-In Sheet will make it easier for you and the MCT2D Coordinating Center to make sure you get the credit for attendance.

To Sign In:

1) We will send a link to everyone who attended following the meeting.

2) After typing in your first and last name, your PO and practice will automatically populate in the fields below.
   a) PO employees not associated with a specific practice don't need to select a practice.
   b) If you are associated with multiple practices, please select any from the options.

3) When entering your Zoom name, please make sure to spell it exactly as it appears on your Zoom screen. If your Zoom name does not match between Zoom and this Sign-In Sheet, there may be a delay in receiving your VBR credit.

American Diabetes Association®

ADA Primary Care Updates 2025

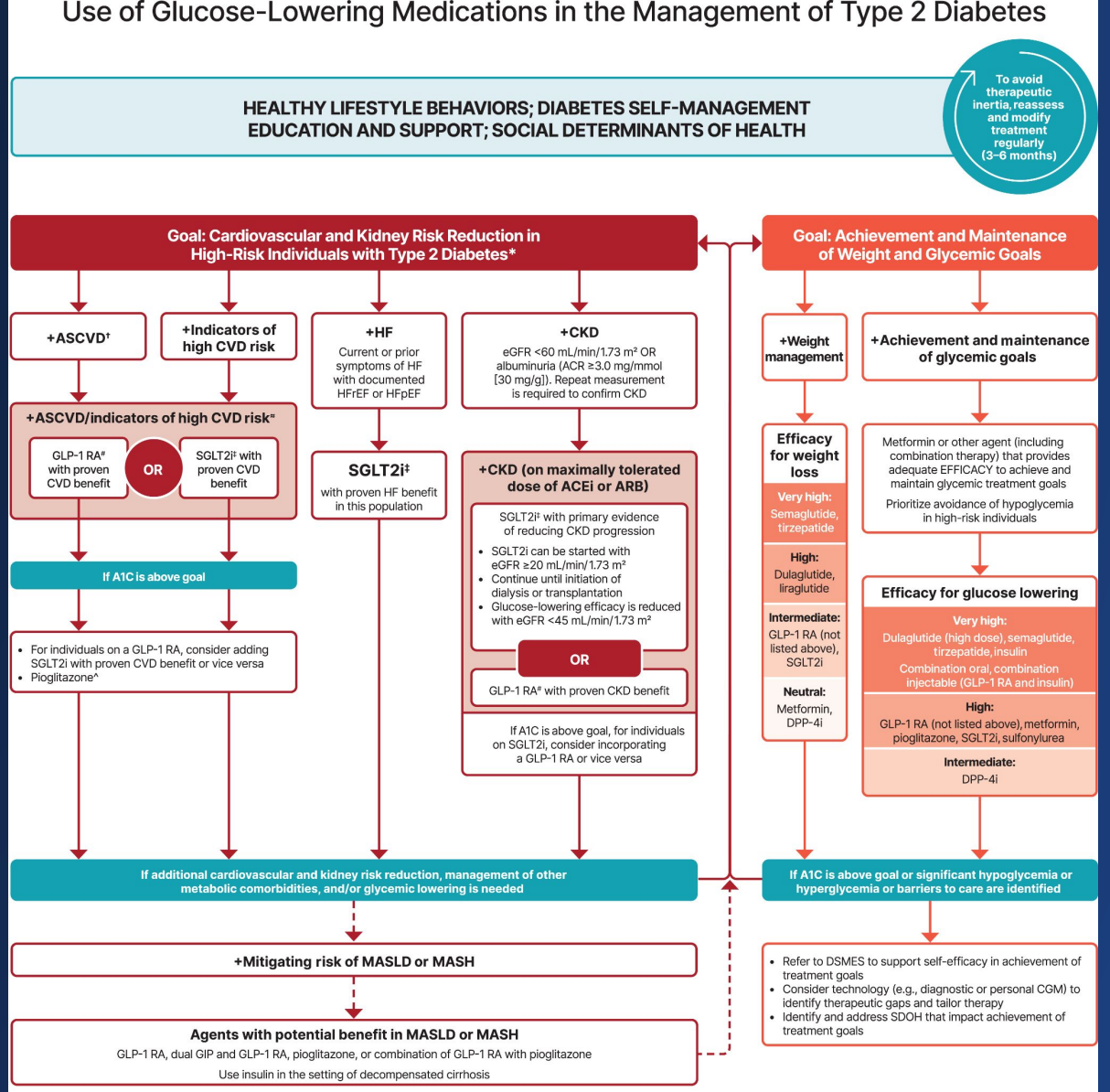
2/27/25

Jonathan Gabison, MD

Objectives:

1. Using Diabetes Education
2. MASLD and MASH
3. CKD Updates
4. Rapid-Fire Updates

Updated Algorithm for T2D Treatment



* In people with HF, CKD, established CVD, or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be made irrespective of background use of metformin or A1C.

† ASCVD: Defined differently across CVOTs but all included individuals with established CVD (e.g., MI, stroke, and arterial revascularization procedure) and variably included conditions such as transient ischemic attack, unstable angina, amputation, and symptomatic or asymptomatic coronary artery disease. Indicators of high risk: While definitions vary, most comprise ≥55 years of age with two or more additional risk factors (including obesity, hypertension, smoking, dyslipidemia, or albuminuria).

≈ A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high-risk CVD. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details.

For GLP-1 RAs, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and kidney end points in individuals with T2D with established or high risk of CVD. One kidney outcome trial demonstrated benefit in reducing persistent eGFR reduction and CV death for a GLP-1 RA in individuals with CKD and T2D.

‡ For SGLT2is, CV and kidney outcomes trials demonstrate their efficacy in reducing the risks of composite MACE, CV death, all-cause mortality, MI, HHF, and kidney outcomes in individuals with T2D and established or high risk of CVD.

^ Low-dose pioglitazone may be better tolerated and similarly effective as higher doses.

Case: Maria 52 years old

CC: Diabetes return visit

PMH: T2D for 12 years, BMI 31, HTN

Meds: Metformin, Semaglutide SQ, Empagliflozin, Losartan, Atorvastatin

VS: BP 124/72, HR 68

Reports decreased energy levels

Diabetes Distress (5.48)

- **Emotional distress** from diabetes management burdens
- **Triggers:** Blood glucose struggles, complication fears, self-care challenges
- **Prevalence:** Over 60% experience distress
- **DAWN2 Study:** 45% reported distress, only 24% had provider support
- **Screening:** People with diabetes, caregivers, family

1. Fisher L, Polonsky WH, Perez-Nieves M, Desai U, Strycker L, Hessler D. A new perspective on diabetes distress using the type 2 diabetes distress assessment system (T2-DDAS): Prevalence and change over time. J Diabetes Complications. 2022 Aug;36(8):108256. doi: 10.1016/j.jdiacomp.2022.108256. Epub 2022 Jul 5. PMID: 35810147.

2. Nicolucci A, Kovacs Burns K, Holt RI, Comaschi M, Hermanns N, Ishii H, Kokoszka A, Pouwer F, Skovlund SE, Stuckey H, Tarkun I, Vallis M, Wens J, Peyrot M; DAWN2 Study Group. Diabetes Attitudes, Wishes and Needs second study (DAWN2™): cross-national benchmarking of diabetes-related psychosocial outcomes for people with diabetes. Diabet Med. 2013 Jul;30(7):767-77. doi: 10.1111/dme.12245. Erratum in: Diabet Med. 2013 Oct;30(10):1266. PMID: 23711019.

Diabetes Distress Update

- Screen for diabetes distress **at least annually** in people with diabetes, caregivers, and family members, and repeat screening when treatment goals are not met, at transitional times, and/or in the presence of diabetes complications. (5.48)
- Tools for screening: PHQ9, GAD7, PAID Scale

Problem Areas In Diabetes (PAID) Scale

Instructions: Which of the following diabetes issues are **currently** a problem for you? Tick the box that gives the best answer for you. Please provide an answer for each question.

		Not a problem	Minor problem	Moderate problem	Somewhat serious problem	Serious problem
1	Not having clear and concrete goals for your diabetes care?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2	Feeling discouraged with your diabetes treatment plan?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3	Feeling scared when you think about living with diabetes?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4	Uncomfortable social situations related to your diabetes care (e.g. people telling you what to eat)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5	Feelings of deprivation regarding food and meals?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6	Feeling depressed when you think about living with diabetes?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7	Not knowing if your mood or feelings are related to your diabetes?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8	Feeling overwhelmed by your diabetes?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9	Worrying about low blood glucose reactions?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10	Feeling angry when you think about living with diabetes?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11	Feeling constantly concerned about food and eating?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12	Worrying about the future and the possibility of serious complications?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13	Feelings of guilt or anxiety when you get off track with your diabetes management?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
14	Not accepting your diabetes?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
15	Feeling unsatisfied with your diabetes physician?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
16	Feeling that diabetes is taking up too much of your mental and physical energy every day?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
17	Feeling alone with your diabetes?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18	Feeling that your friends and family are not supportive of your diabetes management efforts?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19	Coping with complications of diabetes?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20	Feeling burned out by the constant effort needed to manage diabetes?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

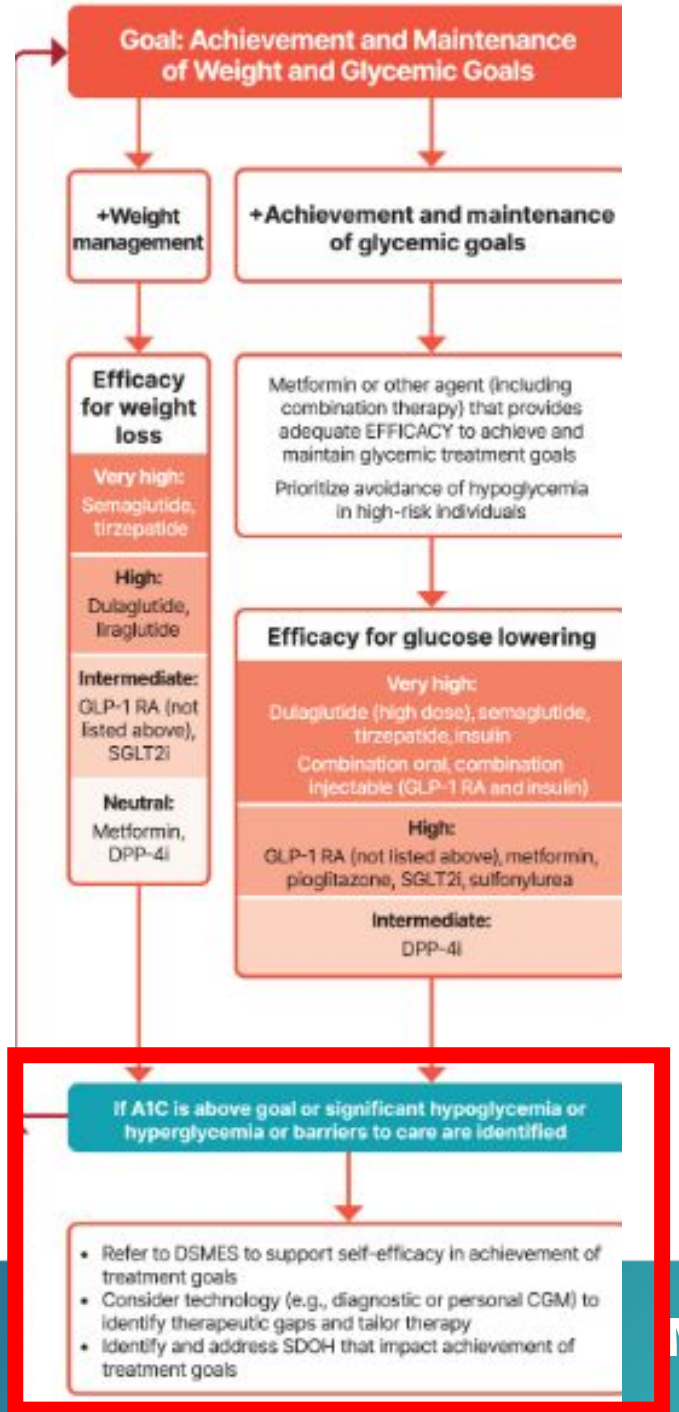
What Should We Do?

Support

Use diabetes self-management education and support (DSMES) tailored to emotional and practical needs

Referrals

Engage mental health professions for high levels of distress or anxiety disorders



Diabetes Self-Management Education and Support (DSMES)

Key Update: All individuals with diabetes should be advised to participate in DSMES at diagnosis and throughout their care journey (5.1)

Why it matters?

- DSMES improves diabetes knowledge, glycemic control and weight, reduces all-cause mortality, lowers healthcare costs, reduces hospitalizations, improves quality of life
- Focuses on empowering patients to self manage their conditions effectively

DSMES Implementation

When to offer DSMES (5.2)

- At diabetes diagnosis
- Annually for assessment of education needs
- When new complicating factors arise (health status change)
- During transitions of care

How to deliver DSMES

- Tailored to individual needs, including language and cultural considerations
- Incorporate technology: virtual DSMES and app-based education tools
- Leverage interprofessional teams

After the Visit: Maria's Labs

Lab Test	Result	Normal Range
A1C	6.8%	<5.7% (normal); <7.0% (goal for diabetes)
ALT	38 U/L	7–35 U/L
AST	33 U/L	8–30 U/L
Platelets	160 x 10^3/µL	150–400 x 10^3/µL
Creatinine	0.9 mg/dL	0.6–1.1 mg/dL
eGFR	92 mL/min	>90 mL/min
HGB	13.5 g/dL	12.0–15.5 g/dL (women)
Lipids:		
- **Total Cholesterol**	190 mg/dL	<200 mg/dL
- **LDL**	110 mg/dL	<100 mg/dL
- **HDL**	48 mg/dL	>50 mg/dL (women)
- **Triglycerides**	160 mg/dL	<150 mg/dL
TSH	1.8 µIU/mL	0.5–4.5 µIU/mL
Vitamin D	22 ng/mL	>30 ng/mL

When I see patients with T2D even with normal liver enzymes, I calculate a FIB4

1. Never
2. Rarely
3. Sometimes
4. Always

Maria's FIB-4

Fibrosis-4 (FIB-4) Index for Liver Fibrosis

Noninvasive estimate of liver scarring in HCV and HBV patients, to assess need for biopsy.

When to Use | Pearls/Pitfalls | Why Use

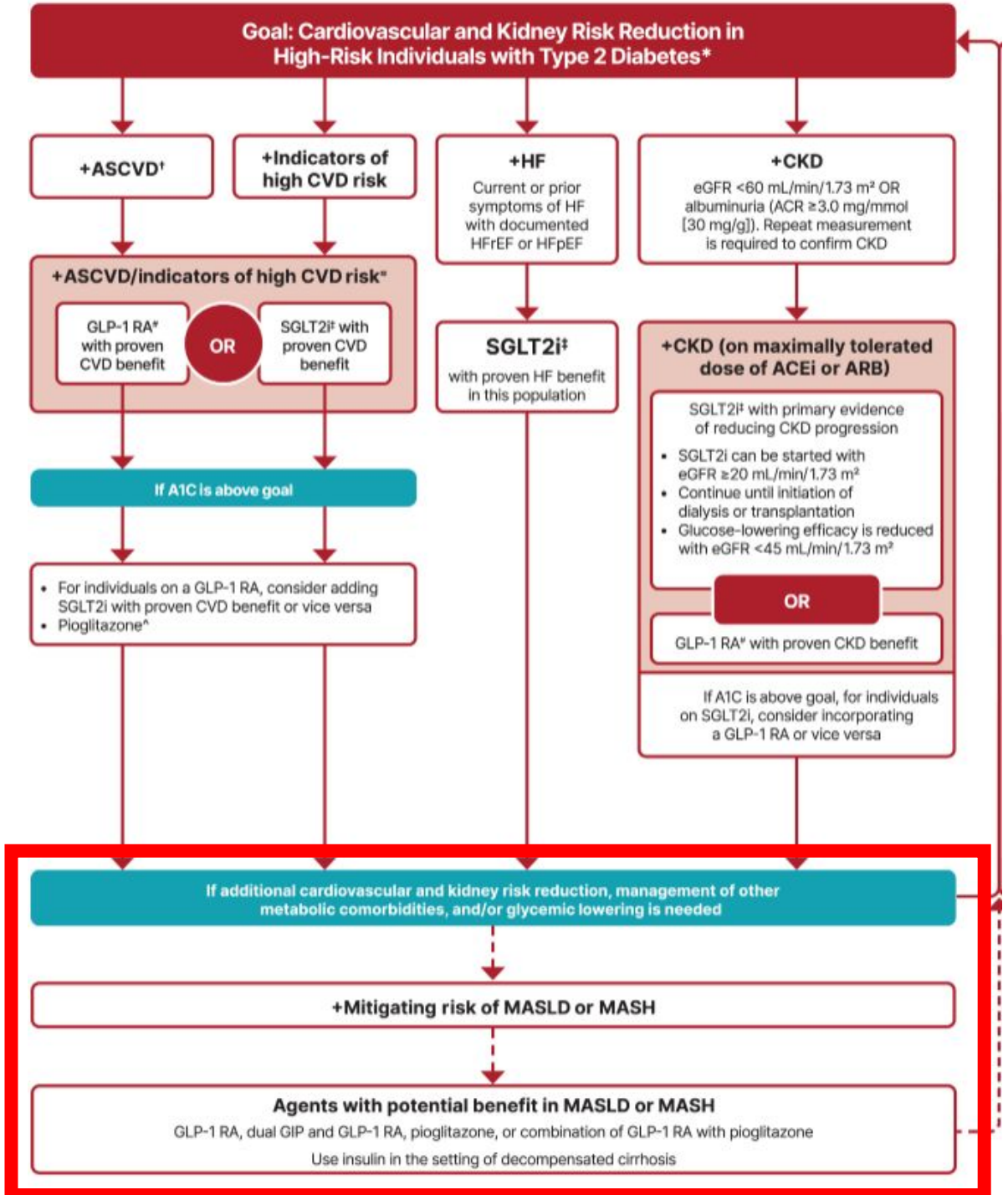
Age Use with caution in patients <35 or >65 years old, as the score has been shown to be less reliable in these patients	52	years
AST Aspartate aminotransferase	33	U/L
ALT Alanine aminotransferase	38	U/L
Platelet count	160	× 10^3/μL

1.74 points

Further investigation needed

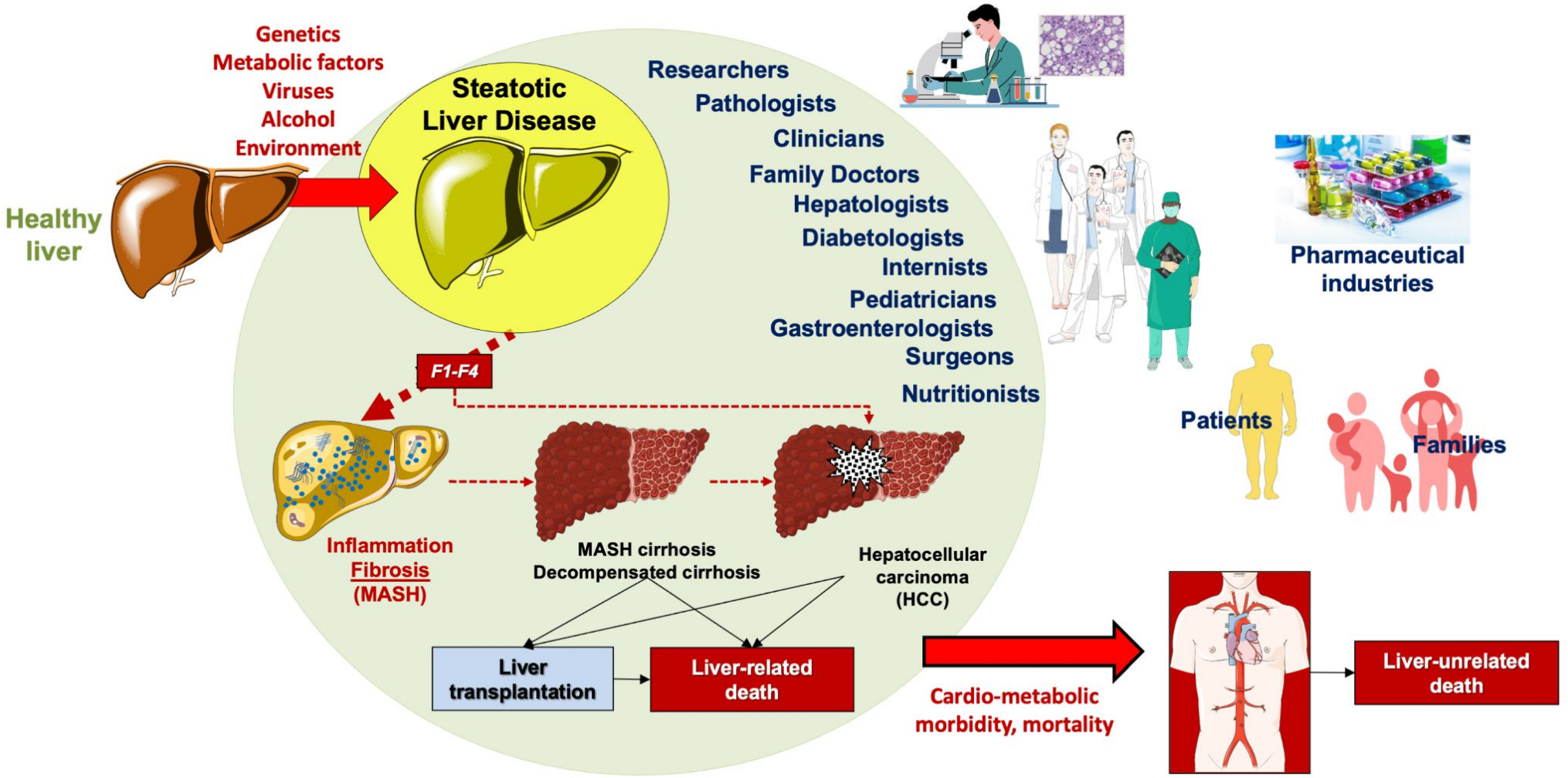
Approximate fibrosis stage: Ishak 2-3 (Sterling et al 2006)

Back to the Algorithm



Metabolic Associated Steatosis Liver Disease (MASLD) or Metabolic Associated Steatohepatitis (MASH)

NAFLD$_{(1980)}$ → MAFLD$_{(2020)}$ → MASLD$_{(2023)}$



Metabolic Associated Steatosis Liver Disease (MASLD) or Metabolic Associated Steatohepatitis (MASH)

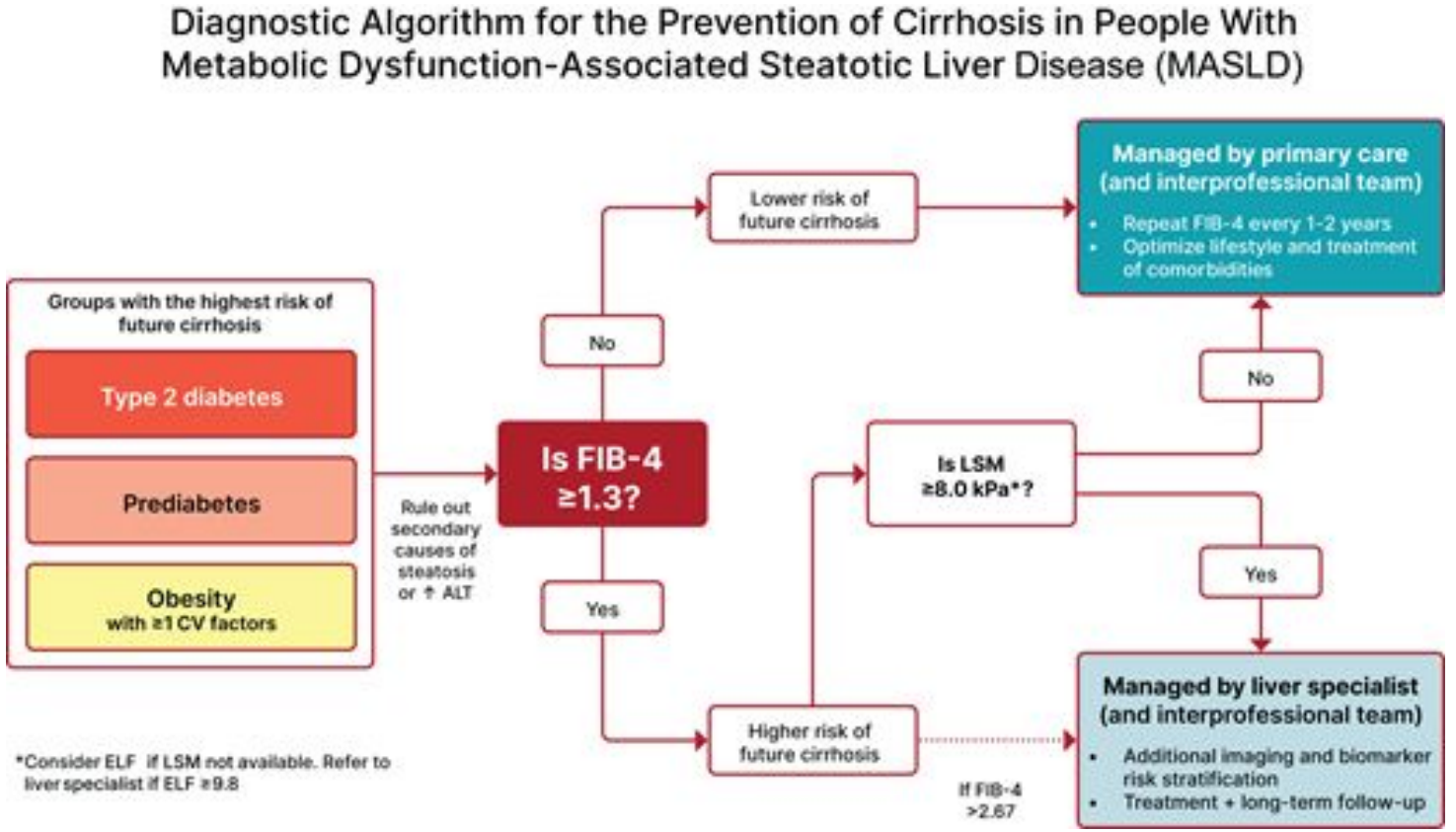
- No longer use MAFLD or MASH
- Estimated > 70% of people with T2D have MASLD
- Diabetes is a major risk factor for development of MASH
- People with T2D have increased risk of cirrhosis and hepatocellular carcinoma
- MASLD: presence of steatotic liver disease and at least one cardiometabolic risk factor associated with insulin resistance without other identifiable cause for steatosis.
  - Formally diagnosed with imaging (> 5% of hepatocytes with hepatic steatosis)
  - Mild elevations in ALT and AST, with ALT > AST is suggestive
- MASH: > 5% hepatic steatosis with inflammation and hepatocyte injury with or without evidence of liver fibrosis
  - Gold Standard: Liver Biopsy

Screening for Fibrosis (4.22, 4.23)

Who to Screen:
- Adults with T2D or prediabetes

How to Screen:
- FIB-4 (ALT, AST, Age, platelets)
- Screen even if liver enzymes are normal

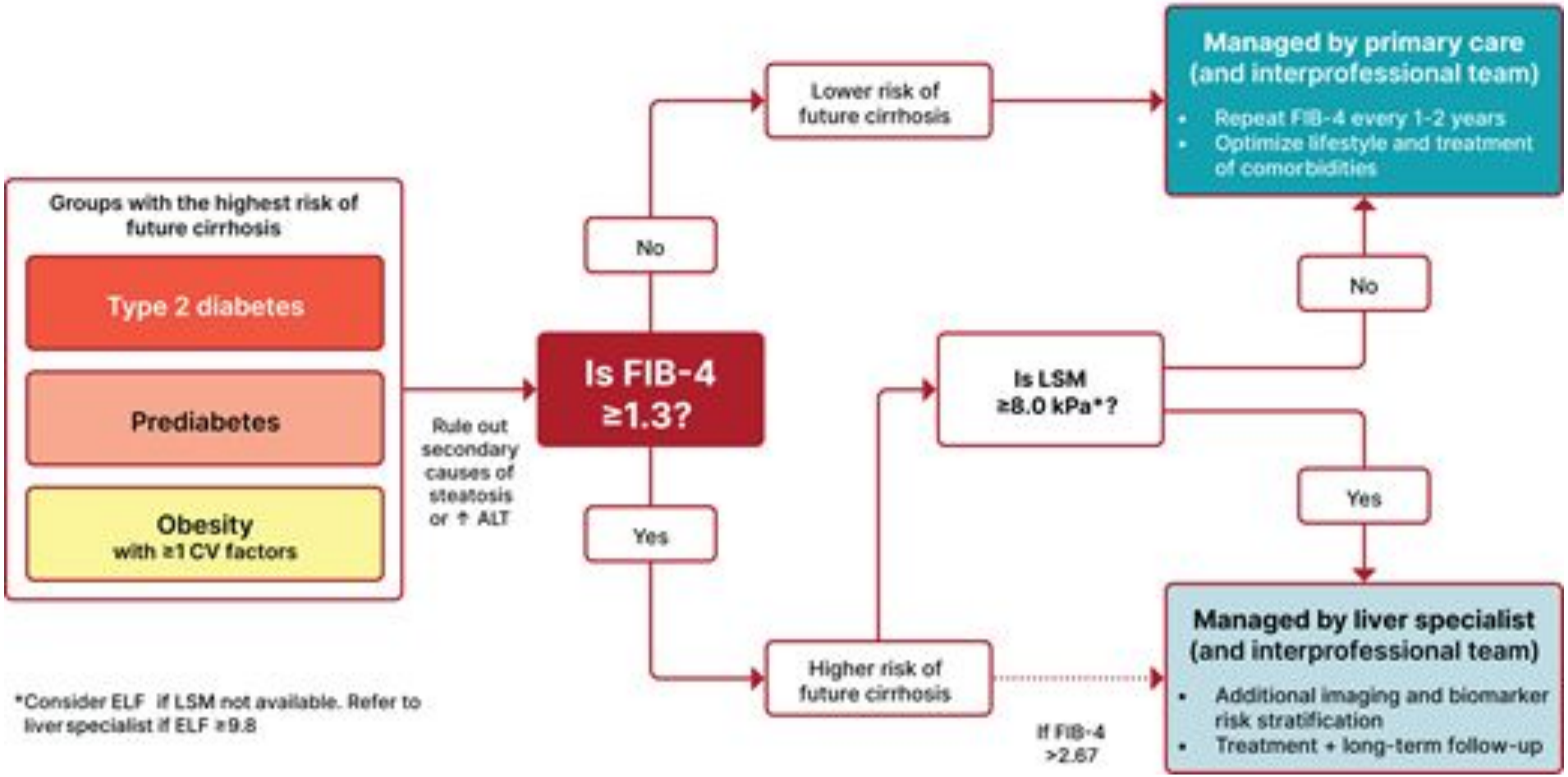
Next steps:
- FIB-4 ≥ 1.3 Perform additional liver risk stratification
  - FIBROSCAN - Transient Elastography (preferred)
  - Enhanced Liver Fibrosis Test (ELF) if elastography not available



Elastography results

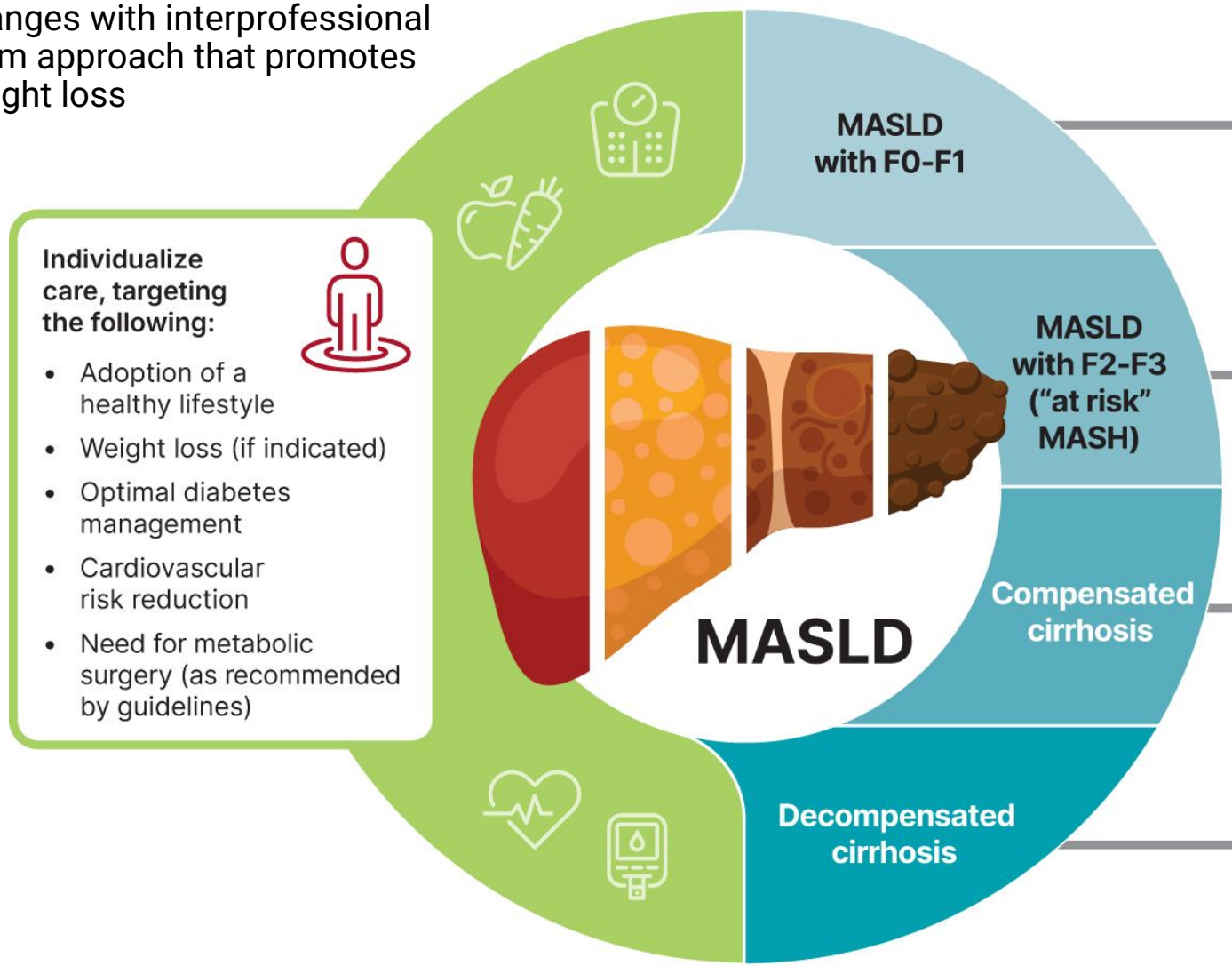
Non-alcoholic Fatty Liver Disease (NAFLD or NASH)	2 to 7 kPa	F0 to F1	Is normal.
	7.5 to 10 kPa	F2	Has moderate scarring.
	10 to 14 kPa	F3	Has severe scarring.
	14 kPa or higher	F4	Has cirrhosis.

Diagnostic Algorithm for the Prevention of Cirrhosis in People With Metabolic Dysfunction-Associated Steatotic Liver Disease (MASLD)



Metabolic Dysfunction–Associated Steatotic Liver Disease (MASLD) Treatment Algorithm

- 4.25 – recommend lifestyle changes with interprofessional team approach that promotes weight loss



Obesity pharmacotherapy	Diabetes pharmacotherapy	MASH pharmacotherapy
Prefer GLP-1 RA, dual GIP and GLP-1 RA	Prefer GLP-1 RA, dual GIP and GLP-1 RA, pioglitazone, SGLT2i	Not indicated

Obesity pharmacotherapy	Diabetes pharmacotherapy	MASH pharmacotherapy
Prefer GLP-1 RA, dual GIP and GLP-1 RA	Prefer GLP-1 RA, dual GIP and GLP-1 RA, pioglitazone	Resmetirom

Obesity pharmacotherapy	Diabetes pharmacotherapy	MASH pharmacotherapy
As with F2-F3 with caution*	As with F2-F3 with caution*	ⓘ AVOID

Obesity pharmacotherapy	Diabetes pharmacotherapy	MASH pharmacotherapy
ⓘ AVOID	Only use insulin	ⓘ AVOID

*Individualized care and close monitoring needed in compensated cirrhosis given limited safety data available.

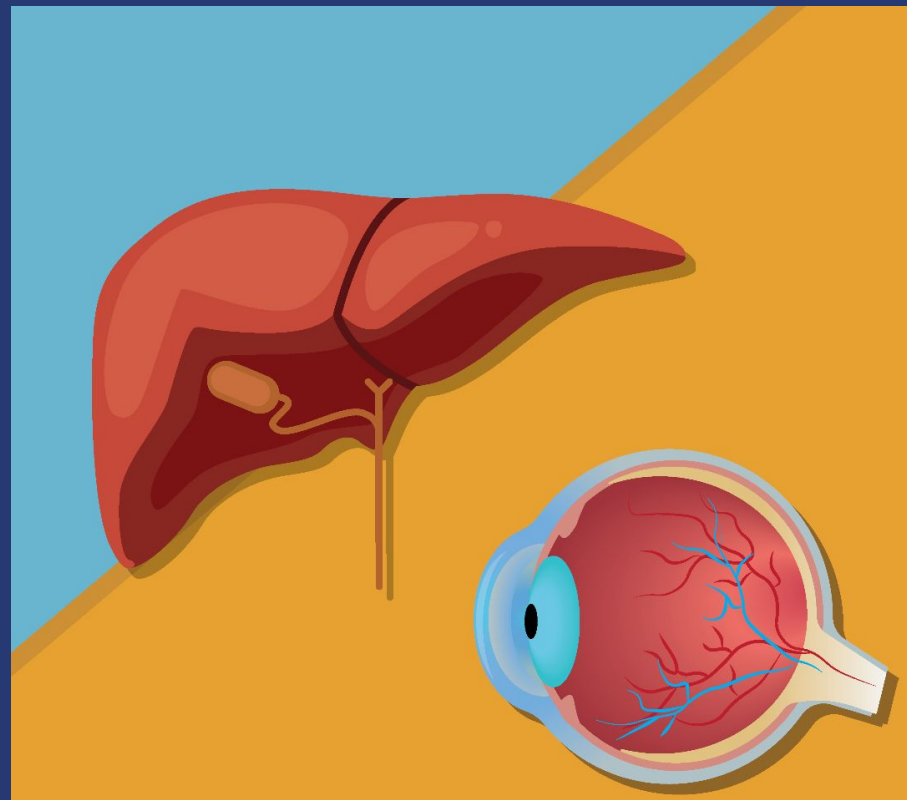
Pioglitazone (TZD)

Class: Thiazolidinedione (TZD)

Pros	Cons
Improves Insulin sensitivity in liver, muscle and adipose tissue	Weight gain (fluid retention and adiposity)
Reduces hepatic steatosis and inflammation	Incidence of heart failure (OR 1.47)
Slows fibrosis progression	Increase odds of bone fractures in women (OR 2.05)
Reduced stroke risk (especially recurrent stroke)	Potential increased bladder cancer risk (conflicting data)
Cost ($10-15 per month)	

We will have another talk on liver disease and retinopathy (if you want more information come back on June 13th)

Any questions before starting next case?



DIABETES COMPLICATIONS:
PART 2- LIVER DISEASE AND DIABETIC RETINOPATHY

6/13/25

Liver Disease: Elliott Tapper, MD
Eye Care: Tom Gardner, MD

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Case: John 58 years old

PMH: T2DM for 10 years, HTN, HLD, OSA (on CPAP), BMI 34

New diagnosis of CKD stage 3a (eGFR 58 mL/min)

Medications: Metformin 1000 mg bid, HCTZ 25 mg, atorvastatin 40 mg

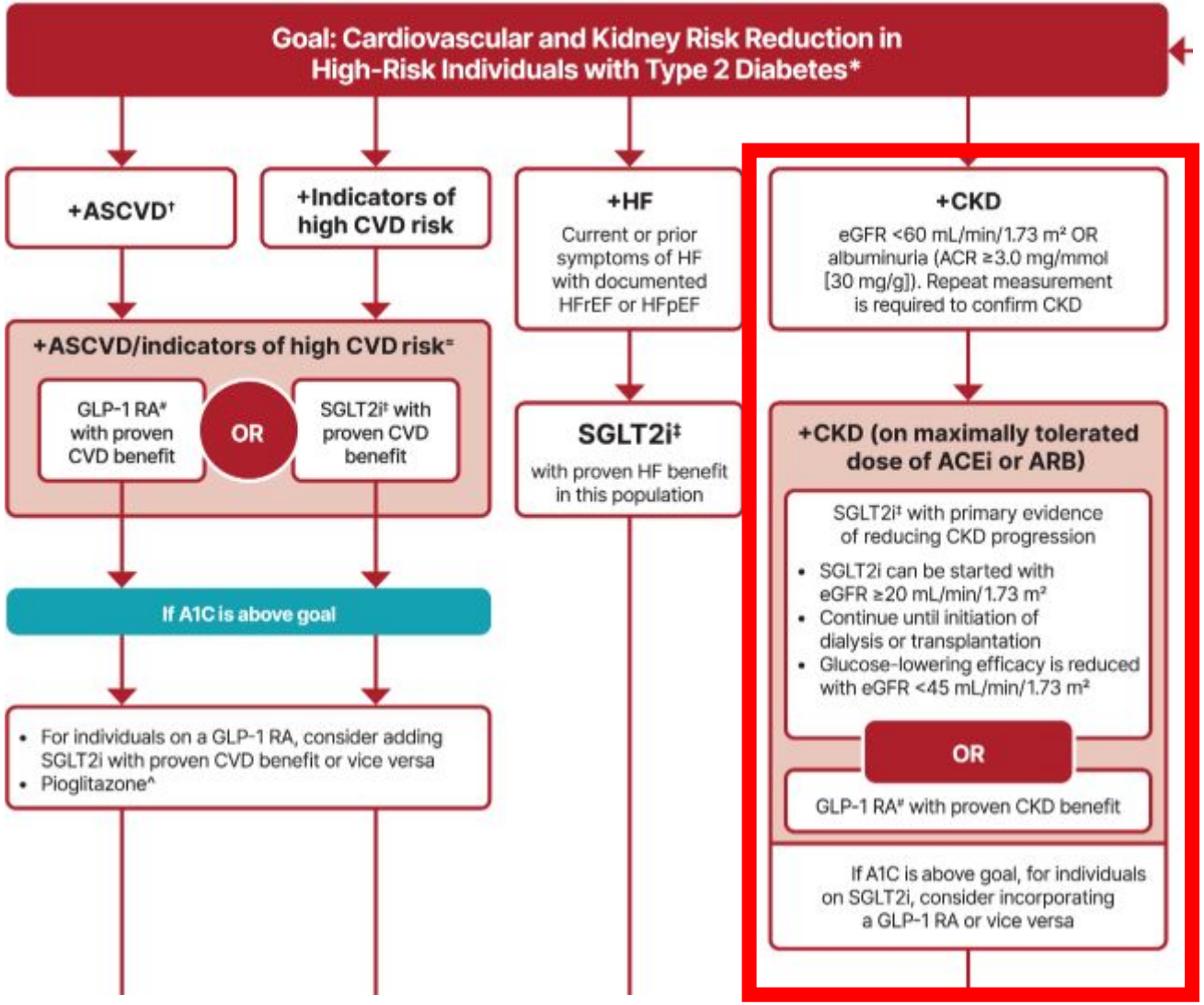
CC: Diabetes return visit

1. Reports reduced energy and stamina
2. No chest pain, but notes calf discomfort when walking long distances, which resolves with rest

After the Visit: John’s Labs

Lab Test	Result	Normal Range
A1C	7.5%	<7.0% (goal for diabetes)
Creatinine	1.3 mg/dL	0.6–1.1 mg/dL
eGFR	58 mL/min	>90 mL/min
ALT	30 U/L	7–35 U/L
AST	28 U/L	8–30 U/L
Platelets	170 x 10^3/µL	150–400 x 10^3/µL
LDL	110 mg/dL	<100 mg/dL
HDL	45 mg/dL	>40 mg/dL (men)
Triglycerides	180 mg/dL	<150 mg/dL
TSH	2.1 µIU/mL	0.5–4.5 µIU/mL
Urinary Albumin/Cr	45 mg/g	<30 mg/g

Treatment for People with Diabetes and CKD



Classification of Chronic Kidney Disease (CKD)

CKD is classified based on:

- **GFR (G)**
- **Albuminuria (A)**

GFR categories (mL/min/1.73 m²) Description and range				Albuminuria categories Description and range		
				A1	**A2**	**A3**
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30-299 mg/g 3-29 mg/mmol	≥300 mg/g ≥30 mg/mmol
	G1	Normal or high	**≥90**	Screen 1	Treat 1	Treat and refer 2
	G2	Mildly decreased	**60-89**	Screen 1	Treat 1	Treat and refer 2
	G3a	Mildly to moderately decreased	**45-59**	Treat 1	Treat 2	Treat and refer 3
	G3b	Moderately to severely decreased	**30-44**	Treat 2	Treat and refer 3	Treat and refer 3
	G4	Severely decreased	**15-29**	Treat and refer 3	Treat and refer 3	**Treat and refer 4+**
	G5	Kidney failure	**<15**	**Treat and refer 4+**	**Treat and refer 4+**	**Treat and refer 4+**

Low risk (if no other markers of kidney disease, no CKD)
Moderately increased risk
High risk
Very high risk

Chronic Kidney Disease Updates

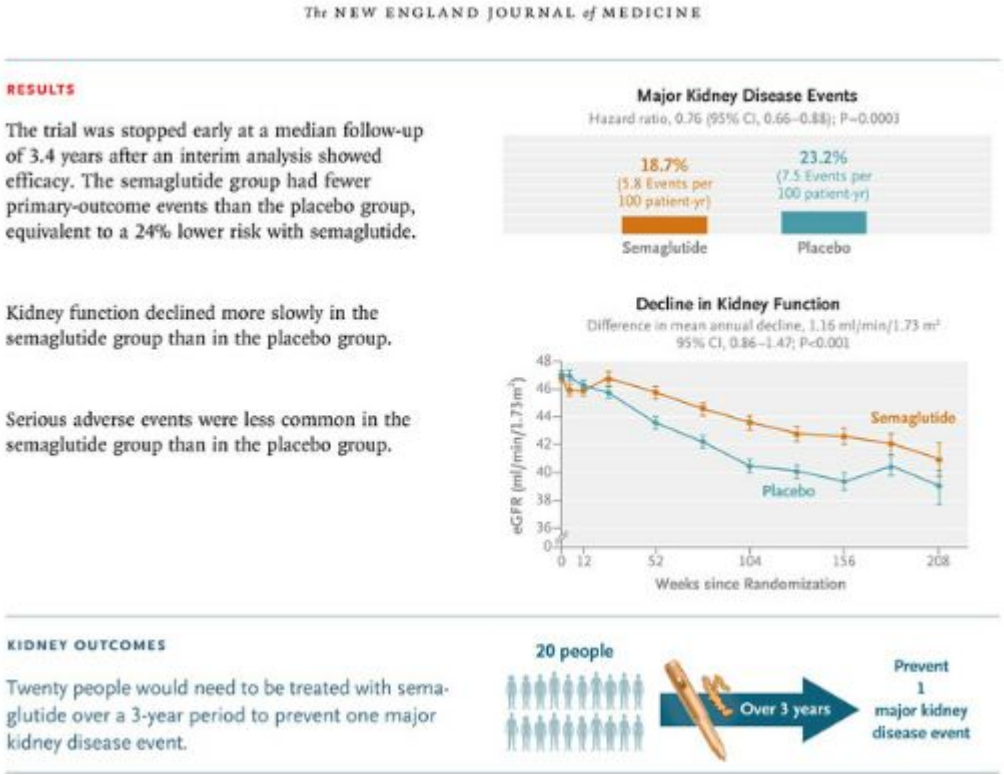
11.5b To reduce cardiovascular risk and kidney disease progression in people with type 2 diabetes and CKD, a glucagon-like peptide 1 agonist with demonstrated benefit in this population is recommended. **A**

Population: Patients with T2D, established CKD (eGFR 50-75 mL/min/1.73m^2 and elevated urinary albumin-to-creatinine ratio)

Intervention: Weekly Semaglutide 1 mg vs Placebo

Primary Outcome: Delayed progression of CKD with reduced incidence of sustained decline in eGFR, end-stage kidney disease or renal death

Results: 24% reduction in risk of major kidney disease events



Critique of FLOW trial

1. Inability to do subgroup analyses
2. Limited use of SGLT2 inhibitors and MRAs
3. Lack of population diversity
4. Generalizability
5. Discontinuation rate in treatment arm (13% of people on semaglutide discontinued their medication)
6. Potential confounding factors

Outcome	Semaglutide (N=1767)	Placebo (N=1766)	Hazard Ratio (95% CI)
Primary outcome: major kidney disease events — no. (%)†	331 (18.7)	410 (23.2)	0.76 (0.66 to 0.88)
Components of primary outcome — no. (%)			
Persistent ≥50% reduction from baseline in eGFR	165 (9.3)	213 (12.1)	0.73 (0.59 to 0.89)
Persistent eGFR <15 ml/min/1.73 m^2	92 (5.2)	110 (6.2)	0.80 (0.61 to 1.06)
Initiation of kidney-replacement therapy	87 (4.9)	100 (5.7)	0.84 (0.63 to 1.12)
Death from kidney-related causes	5 (0.3)	5 (0.3)	0.97 (0.27 to 3.49)
Death from cardiovascular causes	123 (7.0)	169 (9.6)	0.71 (0.56 to 0.89)

Aspect	Canagliflozin	Empagliflozin	Dapagliflozin	Semaglutide
Key Trials	CREDENCE, CANVAS	EMPA-REG OUTCOME, EMPA-KIDNEY	DAPA-CKD, DECLARE-TIMI 58	FLOW, SUSTAIN-6
Primary Outcome	Reduction in CKD progression and CV events	Reduction in CKD progression and CV events	Reduction in CKD progression and CV events	Reduction in major kidney disease events and CV death
CKD Progression	30% reduction in risk of kidney disease progression	39% reduction in risk of incident or worsening nephropathy	39% reduction in risk of kidney disease progression	24% reduction in risk of major kidney disease events
Cardiovascular Outcomes	20% reduction in risk of CV death, MI, or stroke	14% reduction in risk of CV death, MI, or stroke	17% reduction in risk of CV death, MI, or stroke	29% reduction in risk of CV death
eGFR Impact	Effective in patients with eGFR > 30 mL/min/1.73 m²	Effective in patients with eGFR > 20 mL/min/1.73 m²	Effective in patients with eGFR >25 mL/min/1.73 m²	Effective in patients with eGFR 50-75 mL/min/1.73 m²
Albuminuria	Reduces albuminuria progression by 27%	Reduces albuminuria progression by 39%	Reduces albuminuria progression by 29%	Reduces albuminuria progression by 36%

When is Semaglutide appropriate for CKD?

CKD and Blood pressure Management (11.3-11.7)

Blood Pressure Management (11.3)

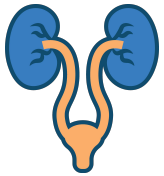
- Optimize BP to reduce risk of CKD progression and cardiovascular risk
- Target BP < 130/80 (GRADE A Recommendation)

ACE/ARB therapy (11.4)

- Titrate to maximally tolerated doses for CKD and CV event prevention
- Monitor BMP 7-14 days after starting or adjusting therapy

Special Considerations in Pregnancy (11.6)

- Avoid harmful antihypertensive medication in reproductive age women without reliable contraception
- Switch to safer alternatives like nifedipine or labetaolol

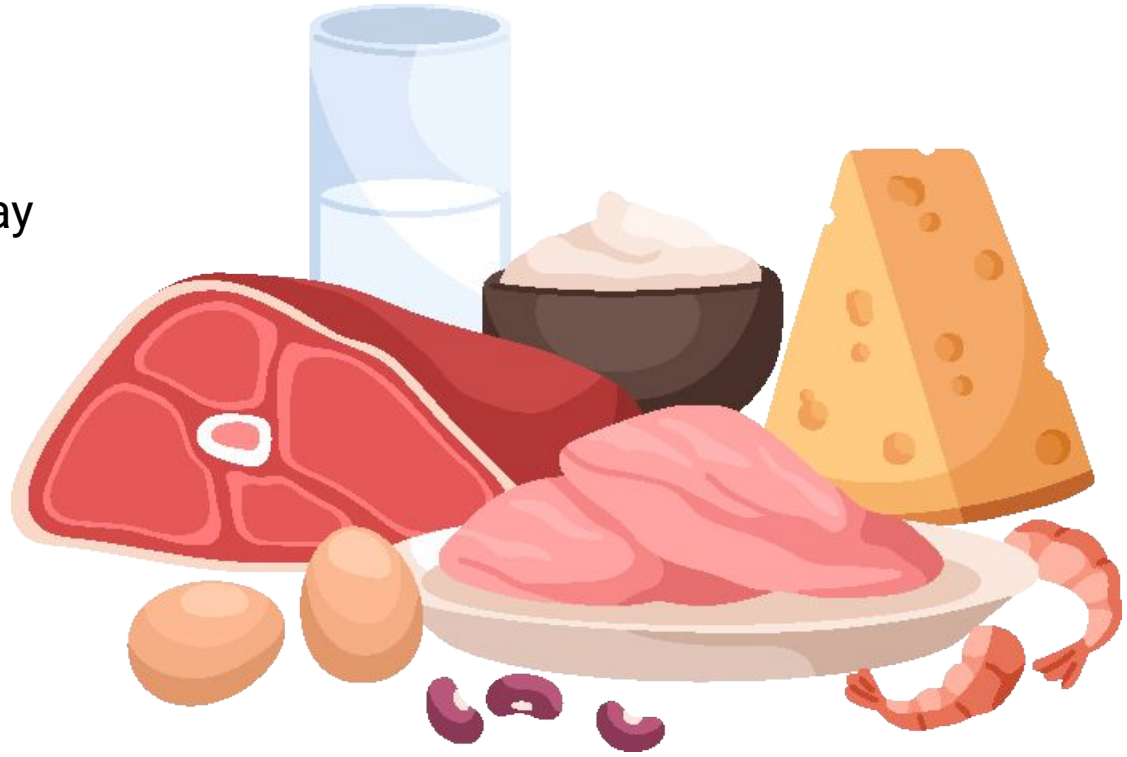


Urinary Albumin Goals (11.7)

- Aim to reduce urinary albumin by > 30% to slow CKD progression

CKD and Nutrition – Updated Protein Goals (11.8)

- Evidence for lower protein intake in people with CKD has been published only for those without diabetes[1]
- Non Dialysis CKD (Stage G3 or higher)
  - Recommended protein intake 0.8g/kg body weight/day (Grade A)
  - Aligns with the general population to reduce CKD progression
- Dialysis Dependent CKD
  - Recommend protein intake 1.0-1.2 g/kg body weight/day (Grade B)
  - Rationale: Addresses protein energy wasting, a major concern in dialysis patients



Case: John 58 years old

PMH: T2DM for 10 years, HTN, HLD, OSA (on CPAP), BMI 34

New diagnosis of CKD stage 3a (eGFR 58 mL/min)

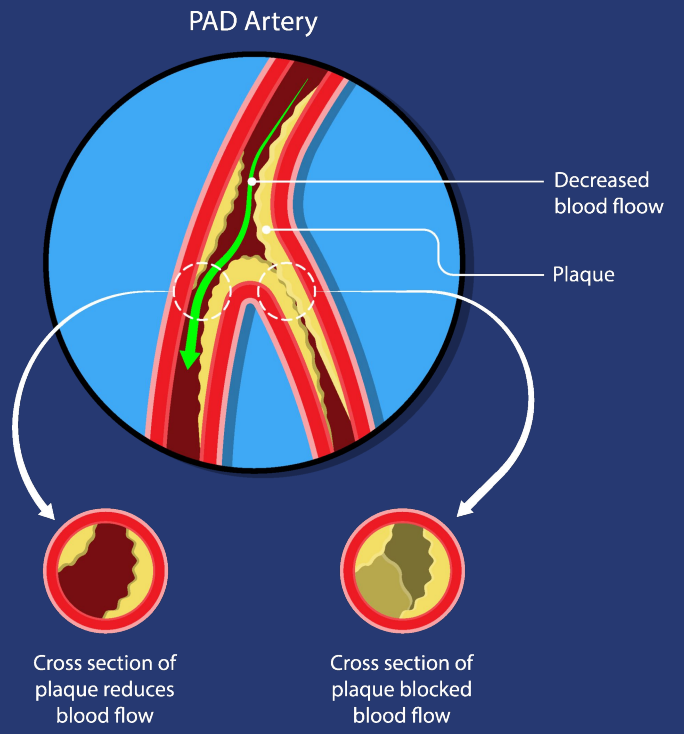
Medications: Metformin 1000 mg bid, HCTZ 25 mg, atorvastatin 40 mg

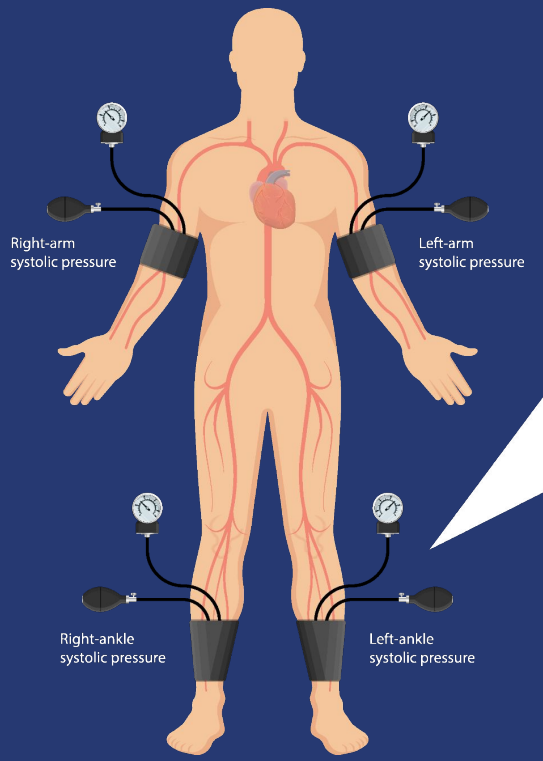
CC:

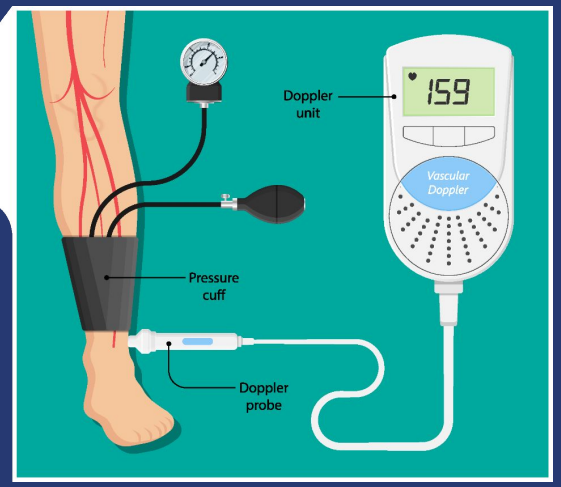
1. Reports reduced energy and stamina
2. No chest pain, but notes **calf discomfort when walking long distances**, which resolves with rest

Peripheral Artery Disease (PAD) Screening

- 26% of people with diabetes have been shown to have PAD
- Diabetes increases odds of having PAD by 85%
- 50% of newly diagnosed PAD are asymptomatic at time of diagnosis
- Vascular screening was associated with:
    - Increased pharmacologic therapy (antiplatelet, lipid-lowering, and antihypertensive therapy)
    - Reduced in-hospital time for PAD and coronary artery disease
    - Reduced mortality



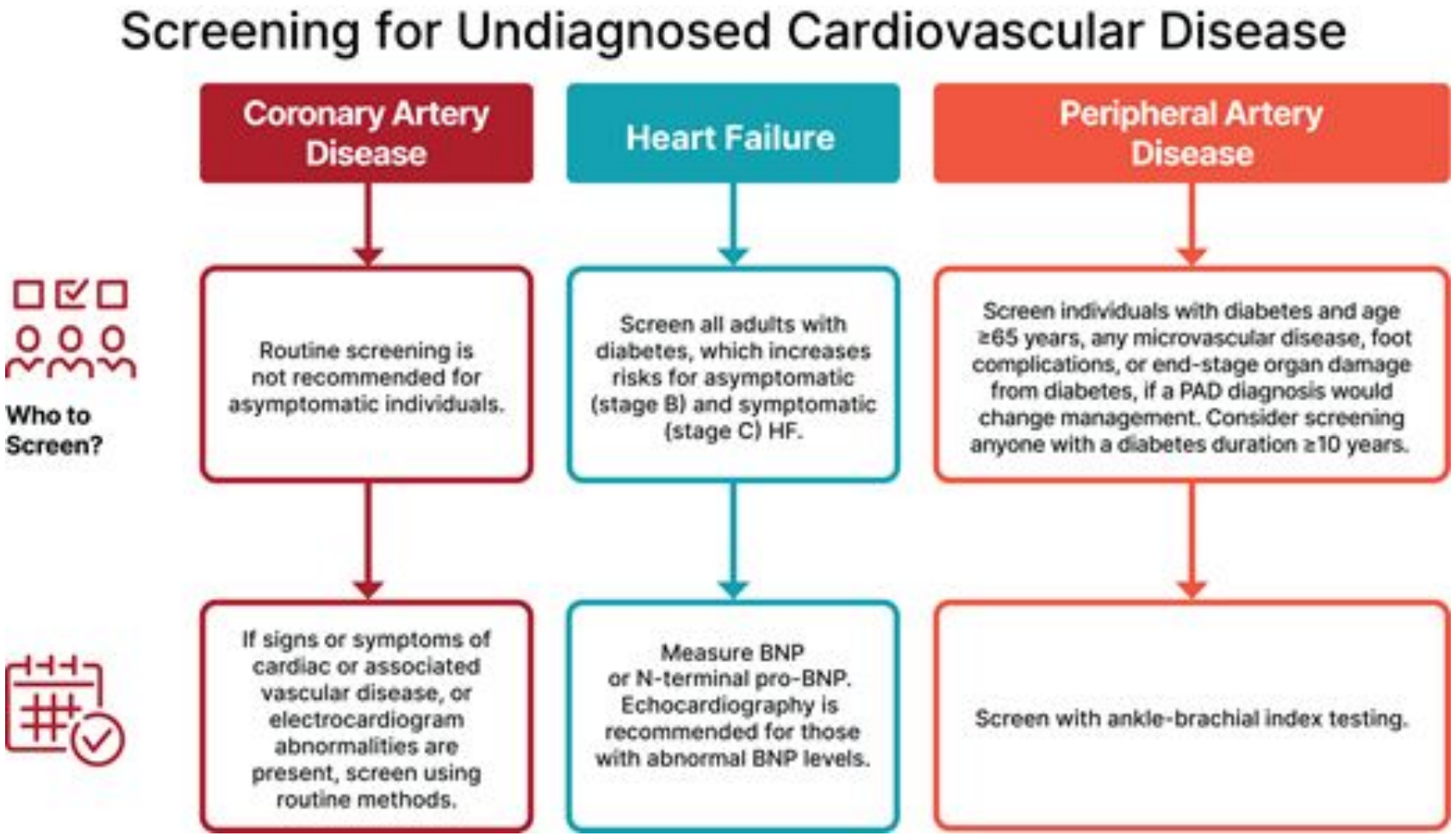




Enhancing PAD Screening in Diabetes (10.41-B)

- Who to screen:
  - Individuals ≥ 65 years old with diabetes
  - Individuals ≤ 65 with additional risk factors (smoking, HTN, dyslipidemia, retinopathy, neuropathy, nephropathy)
  - Individuals with diabetes-related foot complications or organ damage
- Screening method Ankle-Brachial Index

Cardiovascular Risk Screening



Rapid Fire Updates

1. CGM
2. Weight Management
3. Heart Failure with preserved Ejection Fraction (HFpEF)
4. Sleep
5. Bleeding Gums
6. FSD
7. Men’s sexual dysfunction

Updates on CGM for T2D

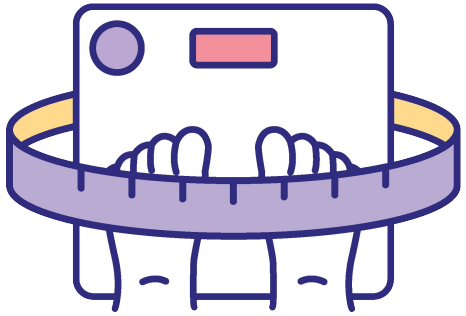
7.16 - **Consider** using CGM in adults with T2D treated with glucose-lowering medications **other than insulin** to achieve and maintain individualized glycemic goals.

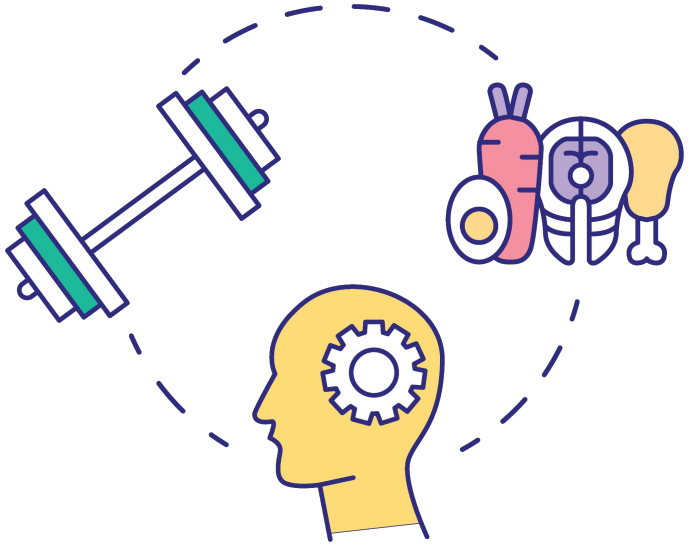
Supporting Evidence

1. Improved Glycemic Control
    - Studies show **greater A1C reduction** with CGM vs. BGM (Blood Glucose Monitoring)
    - **Intermittent CGM use** (1- 2x over 6 mo) improved A1C, with more significant effects in those checking BGM at least 1.5 times/day[2]
    - CGM users saw **more time in range (TIR)** and **less time above range (TAR)**

2. Enhanced Patient Satisfaction
    - CGM use led to **better self-management, reduced stress, and higher treatment satisfaction** compared to BGM[1]

Weight Management





- 8.2B was revised to recommend monitoring of obesity-related anthropometric measurements at least every 3 months during active weight management treatment

- 5.12 Provide weight management treatment based on nutrition, physical activity, and behavioral therapy for all people with overweight or obesity, **aiming for at least 3–7% weight loss** (A)

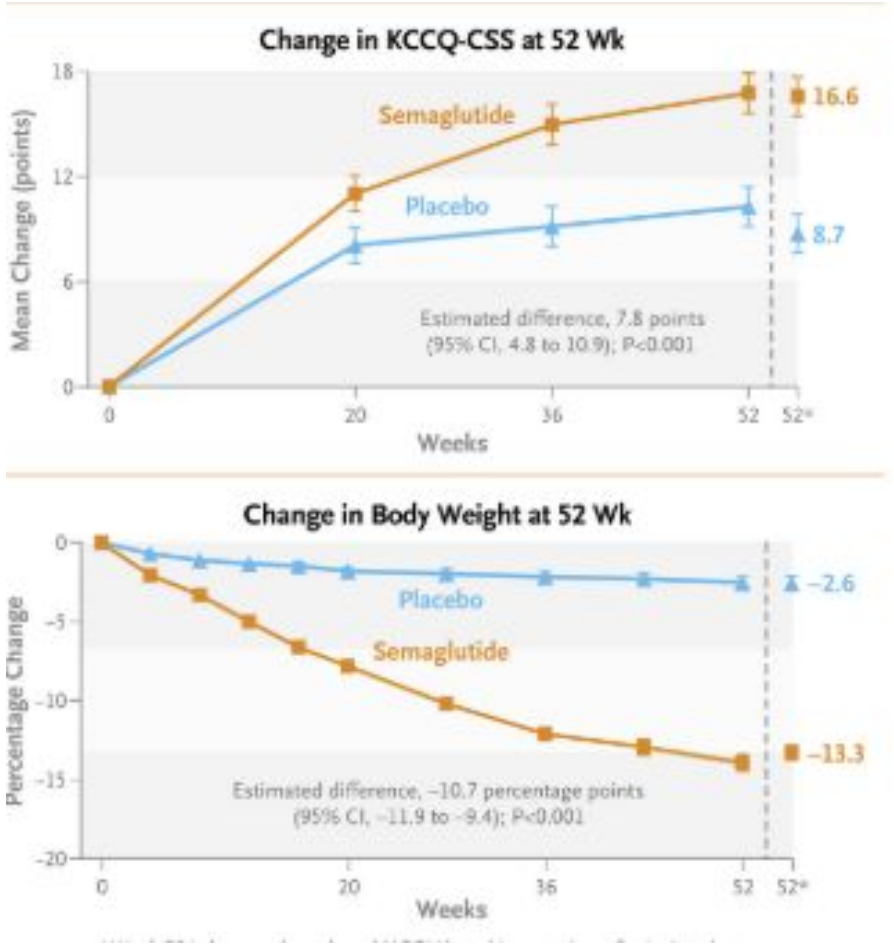
Heart Failure with Preserved Ejection Fraction

Approximately 45% of people admitted for HFpEF have diabetes[2]

10.46d In T2D, obesity, and symptomatic HFpEF, therapy with a GLP-1 RA with demonstrated benefit for reduction of heart failure–related symptoms, physical limitations, and exercise function is recommended. **A**

STEP-HFpEF[1]

- **Population:** Adults with BMI 30 or BMI > 27 with weight-related comorbidity AND symptomatic HFpEF
- **Intervention:** Weekly semaglutide 2.4 mg vs Placebo for 52 weeks
- **Primary Outcome:** Significant improvement in KCCQ-CSS – indicating better symptom relief and quality of life
- **Secondary Outcome:** Improved 6 minute walk distance



Lifestyle Improvements: Sleep (Section 3)

Quantity → < 6 hr and > 9 hr – 50% increase risk of T2D

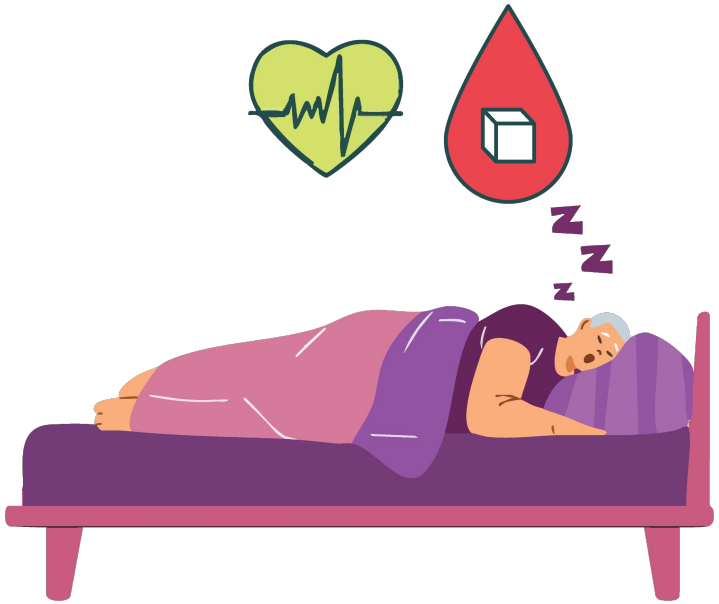
Quality → 40-84% increased risk of T2D

Chronotype → 2.5x risk with late chronotype

Lifestyle Improvements: Sleep (Section 3)

New Emphasis on Sleep

- Recognized as a key component of metabolic health (with nutrition and activity)
- Poor sleep is linked to increased insulin resistance, higher A1c levels, and elevated cardiovascular risks
- Improved sleep quality correlates with better glycemic control and mental health outcomes



Sleep: Recommendations for Providers

- Assess sleep patterns and quality during routine diabetes care visits
- Use validated tools to evaluate for sleep disorders:
  - Obstructive Sleep Apnea (OSA)
  - Insomnia
  - Restless Leg Syndrome
- Encourage sleep hygiene practices
- Refer for sleep study if OSA or other disorders are suspected

Female Sexual Dysfunction (FSD)

Key Facts

- Women with diabetes are at increased risk of sexual dysfunction and less likely to be sexually active
- Women are as likely as men to have sexual dysfunction, but are less likely to discuss with clinician
- **Common issues:** reduced libido, arousal difficulties, vaginal dryness, and dyspareunia

Why it Matters

- Sexual health concerns significantly impact quality of life
- Often underdiagnosed and untreated due to stigma and lack of clinician training

Screening and Assessment for FSD

Routine Screening

- Dialogue about sexual health during diabetes visits

Barriers to Care

- Patient hesitancy to discuss sexual health
- Limited clinician training

Targeted Recommendations:

- Explore sexual health concerns during perimenopause/ menopause

Men’s Sexual Health in Diabetes or Prediabetes

Key Facts:

- 52.5% of men with diabetes have ED.
- Testosterone levels are lower in men with diabetes.

Screening (Recommendation 4.18):

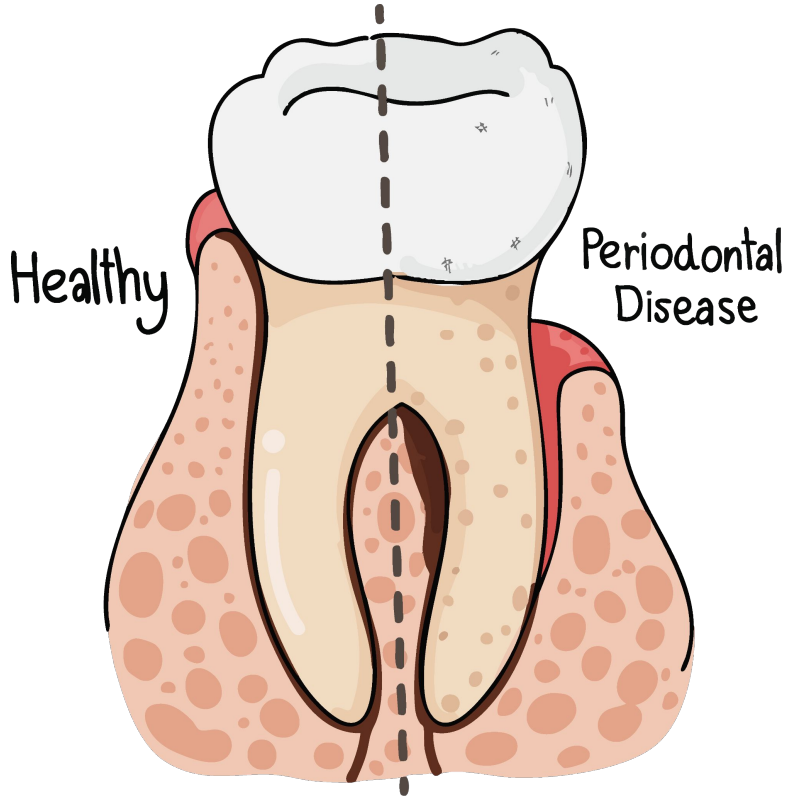
Men with diabetes and hypogonadal symptoms (low libido, ED, depression) should be screened for cardiovascular and endocrine factors, including morning total testosterone.

Treatment:

Consider testosterone replacement for men with low or borderline-low testosterone. In older men with hypogonadism, testosterone therapy increases coronary artery plaque volume, but no clear link to increased cardiovascular risk is established.

Dental Care and Diabetes (4.15, 4.16)

- Poor oral health, particularly periodontal disease is linked to:
  - Worsened glycemic control[1]
  - Increased risk of diabetes-related complications[1]
- Diabetes increases the risk of periodontal disease and delays healing
- Treating periodontal disease can improve A1c by 0.4 - 0.6% over 3 - 6 months[2]



Provider Recommendations for Dental Care

- Assess dental health
  - Are they seeing a dentist?
  - Ask about symptoms (gum bleeding, loose teeth, oral discomfort)

- Coordination with Dentists
  - Glycemic goals
  - Comorbidities that would impact dental care or antibiotic use (kidney, liver, pulmonary conditions)
  - Hypoglycemia risk

Questions?

MCT2D