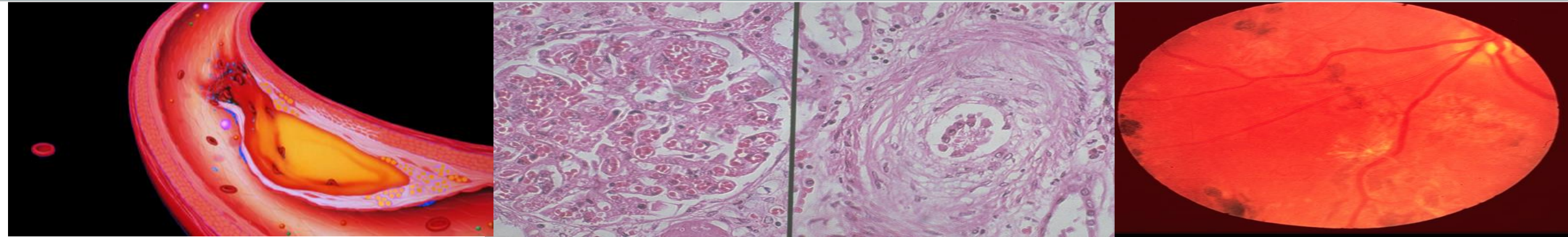


Time To Re - Think T2DM: Cardio-Renal-Metabolic Syndrome Let's Not Sugar Coat Diabetes

***Tools for Professional Practice 2023 & Beyond: Beyond Glycemia
'Turning the Tides' For the Future of Diabetes Care
T2DM, CKDz & ASCVDz: 'When There Is Smoke, There Is Fire'***



Michael Valitutto D.O.
ValituttoMichael@Gmail.com
Medical Director, Borgess Diabetes & Endocrine Center
MOA Autumn Scientific Convention 10/28/23



Objectives

1. Discuss The Need To Address Cardio-Renal-Metabolic Risk In Patients With T2DM Beyond Standard of Care.
2. Establish ASCVDz As The Most Common CVDz in Patients With T2DM.
3. Explore How ASCVDz Impacts Patients With T2DM.
4. Review Recommendations From Major Medical Societies For Patients With T2DM & ASCVDz, Or ASCVDz Risk Factors.
5. Realize The Importance Of A Team-Based Approach To Reduce Cardio-Renal-Metabolic Risk In Patients With T2DM.



Disclosures

- ❖ Speaker Bureau Lilly, Novo, Corsept Therapeutics, Astra-Zeneca, Boehringer Ingelheim, Abbvie, Horizon Therapeutics.
- ❖ I Will Not Discuss Off Label Use And / Or Investigational Use In My Presentation.
- ❖ All MOA Planners, Reviewers, And Course Directors Have No Relevant Financial Relationships With ACCME-Defined Commercial Interests.
- ❖ My Presentation Today Will Be Fair, Balanced, Free of Commercial Bias & Fully Supported By Scientific Evidence



New Patient To The Office

- 64 y/o Male. T2DM Since 2015.
- ACS August 2020, Stent x 2 (LAD, RCA)
- Metformin 1,000 mg BIDay. HbA_{1c} 6.9%
- Should We Modify The Glucose Lowering Medication?

**Treat The Patient
Not Their Sugar
Reduce CV Risk
Not Only The HbA_{1c}**

Pre-2008

2008-2015

Since 2015

HbA_{1c}

HbA_{1c}

CV
Events

No
HbA_{1c} = Good

Yes
No Evidence
Based Medication

Lower
The
Better

Lower Better
Avoid Hypo &
Weight Gain

↓ BP, LDL
↓ Glucose
Agents Proven
Safety Efficacy



The Connection Between A1c & CVDz Is A Key Consideration



**A 1% Increase In Mean A1c Is
Associated With A 22% Greater
Risk Of CV Events In T2DM
Patients**

Retrospective Observational Case-Control Study Using EMR 2,456 Pts With T2DM
Nichols GA et al. *Diabetes Care*. 2014;37(1):167-172



Does Better Control Improve Outcomes?

Meta-Analysis 14 Randomized Controlled Trials

14 Trials
Comprising
95,502
Patients

	Number Trials	RR (95% CI)	P Interaction
MACE	14	0.95	0.23
Expanded MACE	14	0.96	0.17
All-Cause Death	12	0.99	0.67
CV Death	12	0.98	0.92
MI	14	0.92	0.15
Stroke	14	0.99	0.27
HF	14	1.14	0.002
USA	7	0.97	0.05
Coronary Revascularization	6	0.92	0.07

Effects Of Glucose Lowering Medications On CV Outcomes With RCT

	Met	SU	Acarb	TZD	DPP4	SGLT2	GLP1	Basal Insulin	Meal Time Insulin	Intensive Insulin Therapy
Any CVOT	x	x	x	Yes	Yes	Yes	Yes	Yes	x	x
Effects On MACE	x	x	x	++ Pio	= ? CHF	+++	+++	= Glar	x	x



When To Treat T2DM As A Vascular Disease?

- ❖ CVD Leading Cause of Morbidity and Mortality Among Patients with T2DM.
- ❖ ~ 1/3 T2DM Patients Have CVDz. 8x More Likely MI & 7x More CVA.
- ❖ Two Out of Every Three T2DM Patients Die From CVDz.
- ❖ ADA / EASD / ACC Announced An Update To The Standard of Care Guidelines for Medical Co-Management T2DM & Established ASCVDz / CKDz / CHF.
- ❖ Two 'Newer Classes' of Medications, GLP-1 Analogues & SGLT-2i Recommended as a 'Second-Line' Medical Therapy.

Time To Disrupt The Glycemic Centered Approach

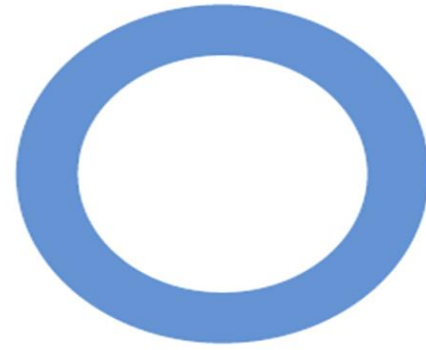
- ❖ Think Of DM As A Vascular Dz. & Preferentially Select Proven Second-Line Classes Of Diabetes Rx. Targeting Preservation Of Heart, Brain, & Kidney Function In Pts With Comorbid T2DM, CVD, HF and / or CKD.
- ❖ While the Recommendation GLP-1 RA & SGLT-2i By the ADA / EASD / ACC Was Based Upon a Thorough Review Of The Literature & Landmark Studies, Clinicians May Not Widely Adopt These Lifesaving Guidelines & Rx. For Their Pts For Years To Come.
- ❖ Unfortunately, Even In The Information Age, Lifesaving Knowledge Travels Slowly - The Legacy Healthcare System.

Bring
diabetes
to light

14 November



“Nourishing Development: Halting the Diabetes Epidemic Through Healthy Eating; Diabetes Education and Prevention”



world diabetes day



Act **t**oday,
to change tomorrow

Off to **the right** start this
World Diabetes Day

Bring
diabetes
to light

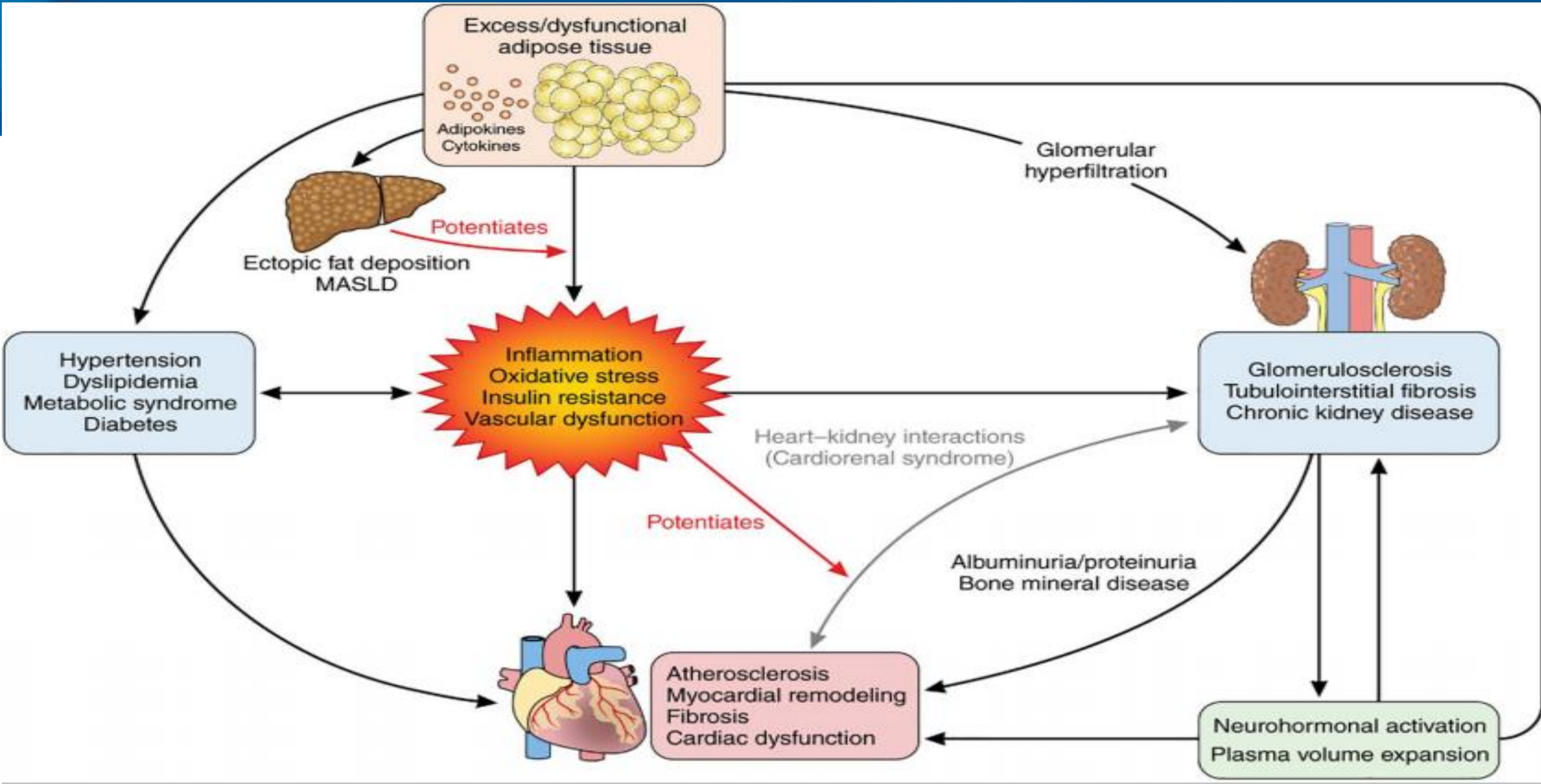
14 November



Global Symbol / Unite for Diabetes Awareness Campaign. Symbolizes Life and Health. Blue Reflects the Sky That Unites All Nations. Circle Signifies Unity of the Global Community.



The Puzzles Of Cardio-Renal-Metabolic Syndrome

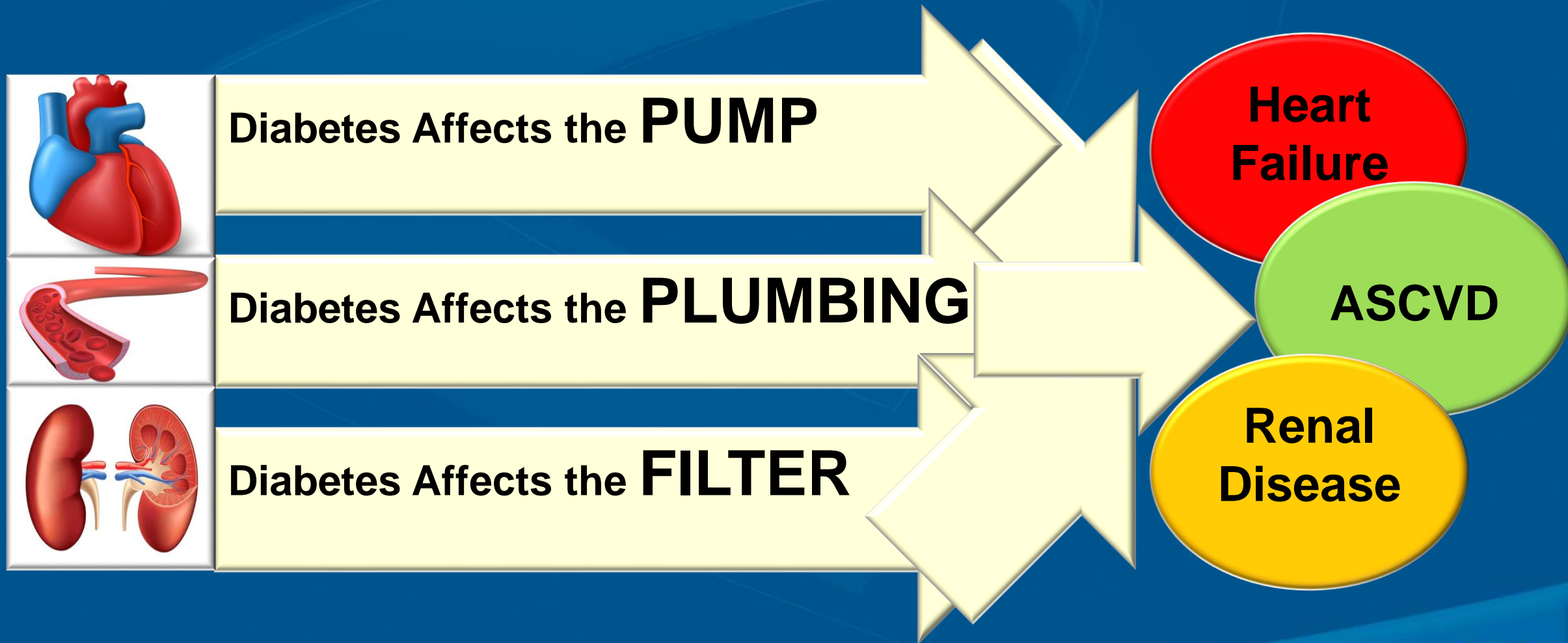


T2DM Affects: Pump, Plumbing & The Filter

- ❖ Treatments That Are Dz Modifying & That Address The Core Pathophysiologic Defects
- ❖ Treatments That Are Effective Independent of Beta Cell Status & Thus Indifferent to Dz Stage
- ❖ Treatments That Are Weight Neutral or That Promote Weight Loss
- ❖ Treatments That Avoid Hypoglycemia
- ❖ Treatments That Are Beneficial In Their Impact On CVDz, CVDz Risk Factors, & Renal Dz
- ❖ Treatments Easily & Reliably Used By Patients In Sustainable Fashion (Improved Adherence)



T2DM: Central Role In CV & Renal Disease



Can We Do More? Will Our Next Move Do Enough?

Residual Risk Remains For Patients With T2DM & Established CV Disease Treated With:

ACE /
ARB's

Statins



ASA /
Anti-
Platelet
Therapy

Diabetes
Meds

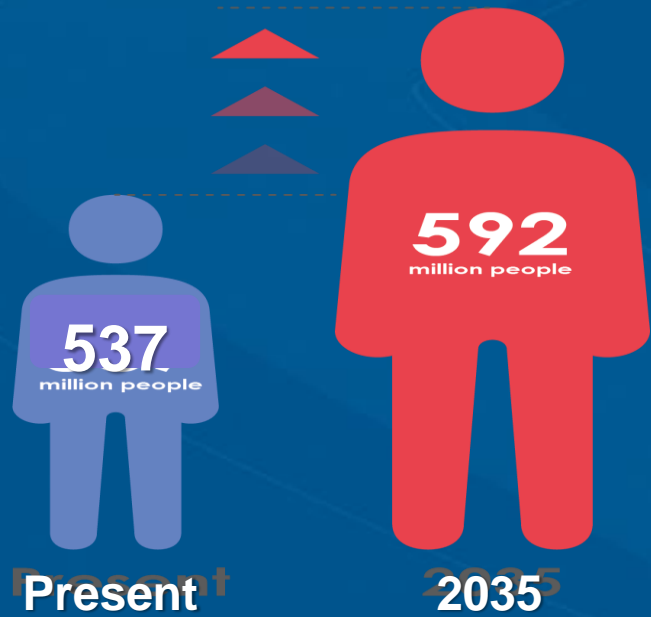
**Incidence of CV Death
Remains Higher in
Patients With Diabetes
Despite Advances In Care**

**‘Despite Our Best Efforts, 2 in 3
Adults with T2DM Will Die From a
CVDz - Related Event’...NIDDK**



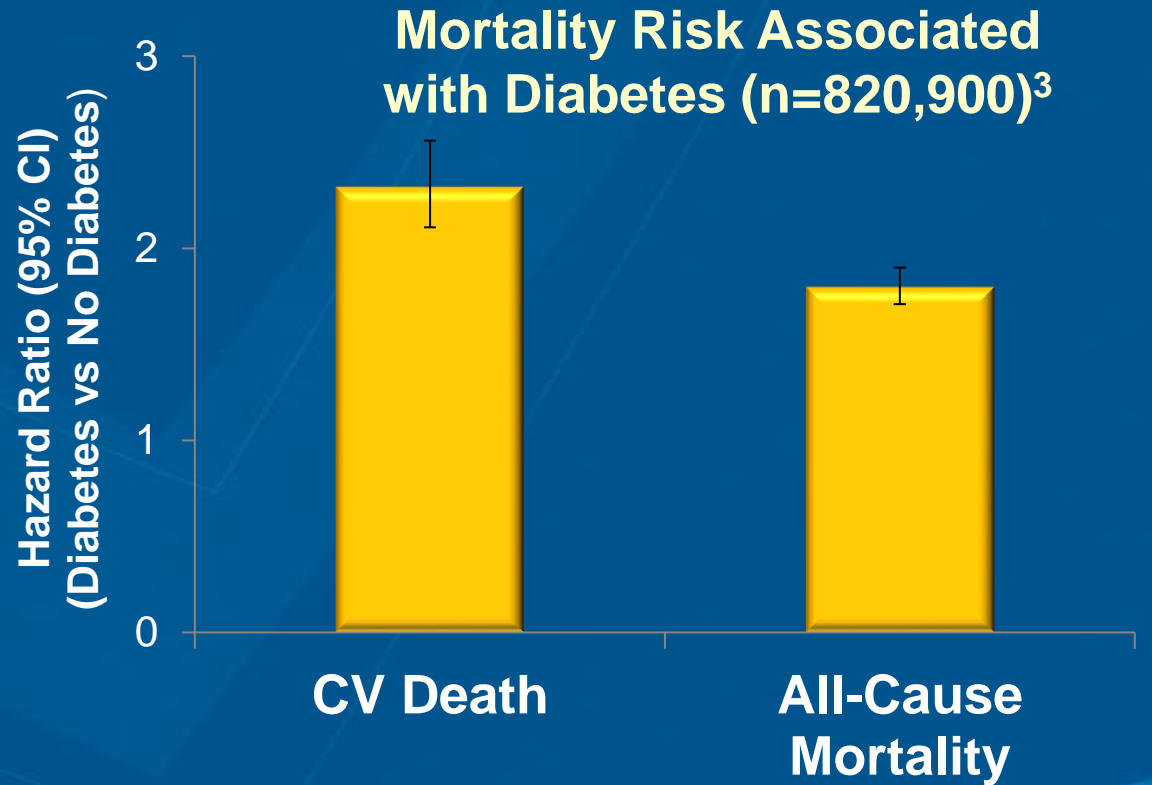
T2DM Increasingly Prevalent

◊ Globally, 537 Million Living with Diabetes¹



↑↑↑ This Will Rise to 700 Million by 2045¹ ↑↑↑

• At Least 68% of People >65 Years with Diabetes Die of Heart Disease²



1. IDF Diabetes Atlas 6th Edition 2018 <http://www.idf.org/diabetesatlas>;
2. Centers for Disease Control and Prevention 2019;
3. Seshasai et al. N Engl J Med 2011;364:829-41



Growing Problem of T2DM and CKD

**~537
MILLION**

**Adults Are
Living with
Diabetes**

30 to 40%

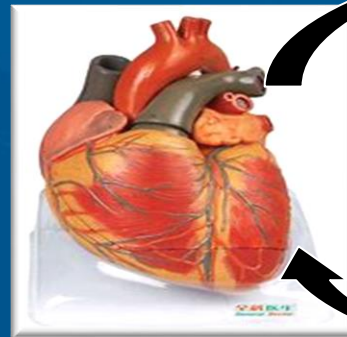
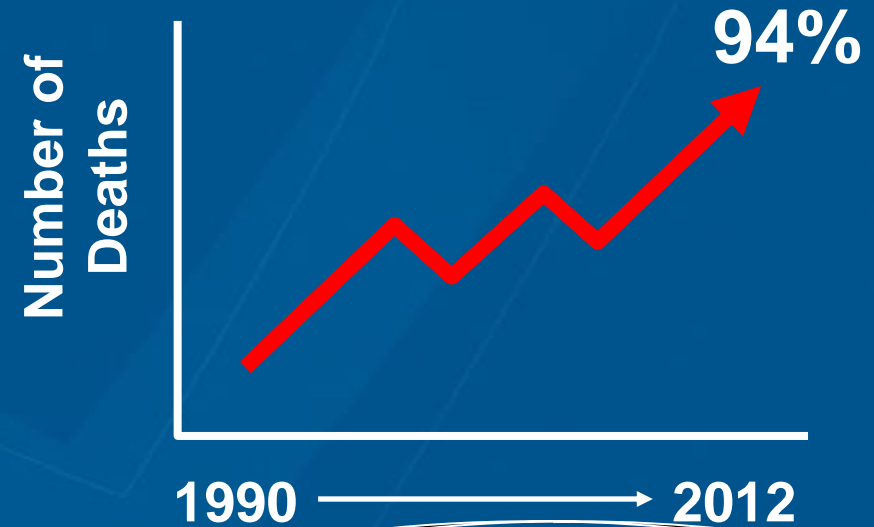
Of These Patients Will Develop CKD



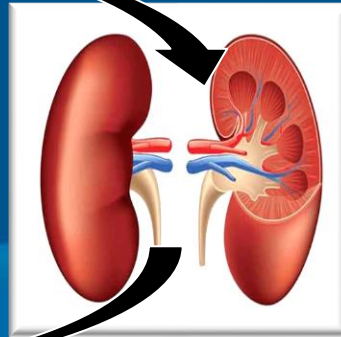
**Renal & Cardiac Systems Are Linked
Acute Or Chronic Disorder of One Can
Induce Dysfunction in the Other**

1. World Health Organization. Global Report on Diabetes. 2020.
2. Yee J. *Diabetes Spectr.* 2008;21(1):8-10.
3. Alicic RZ, et al. *Clin J Am Soc Nephrol.* 2017;12(12):2032-2045.

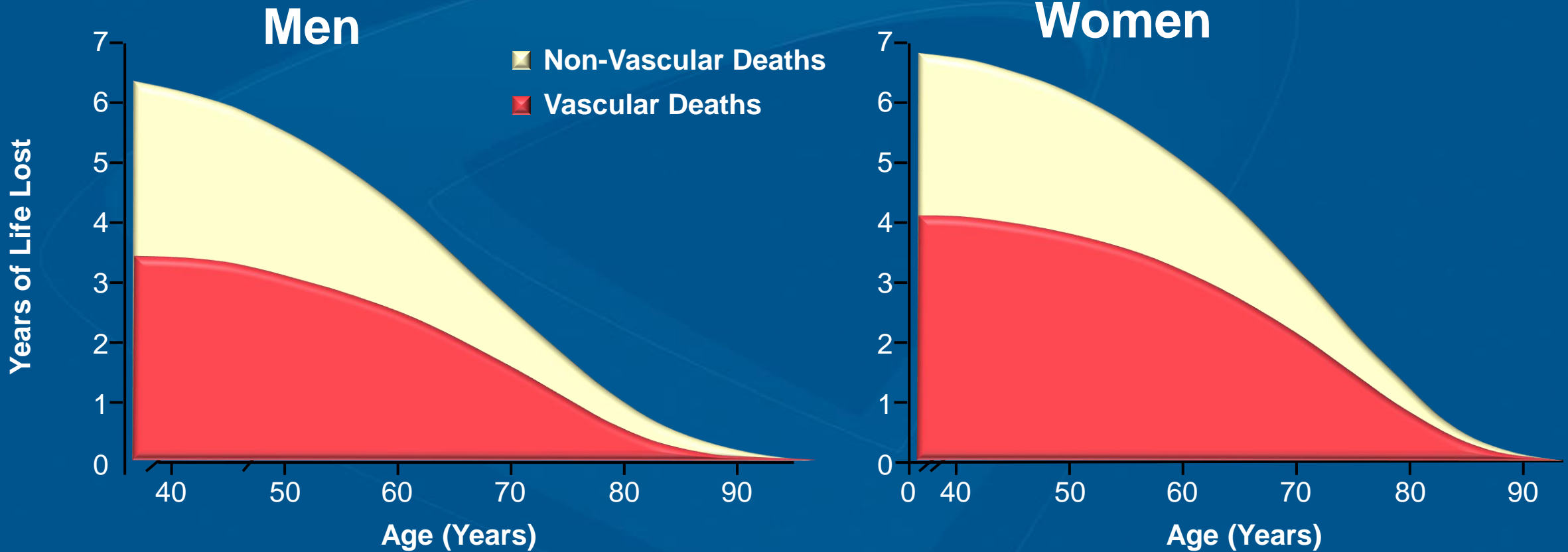
**Deaths D/T
T2DM and CKD**



**CKDz Patients
5 - 6 X
More Likely To Die CVDz
Than Advance To ESRD**



Diabetes is Associated with Significant Loss of Life Years



On Average, a 50-Year-Old Individual with Diabetes and No History of Vascular Disease Will Die ~ 7 Years Earlier Compared to Someone Without Diabetes

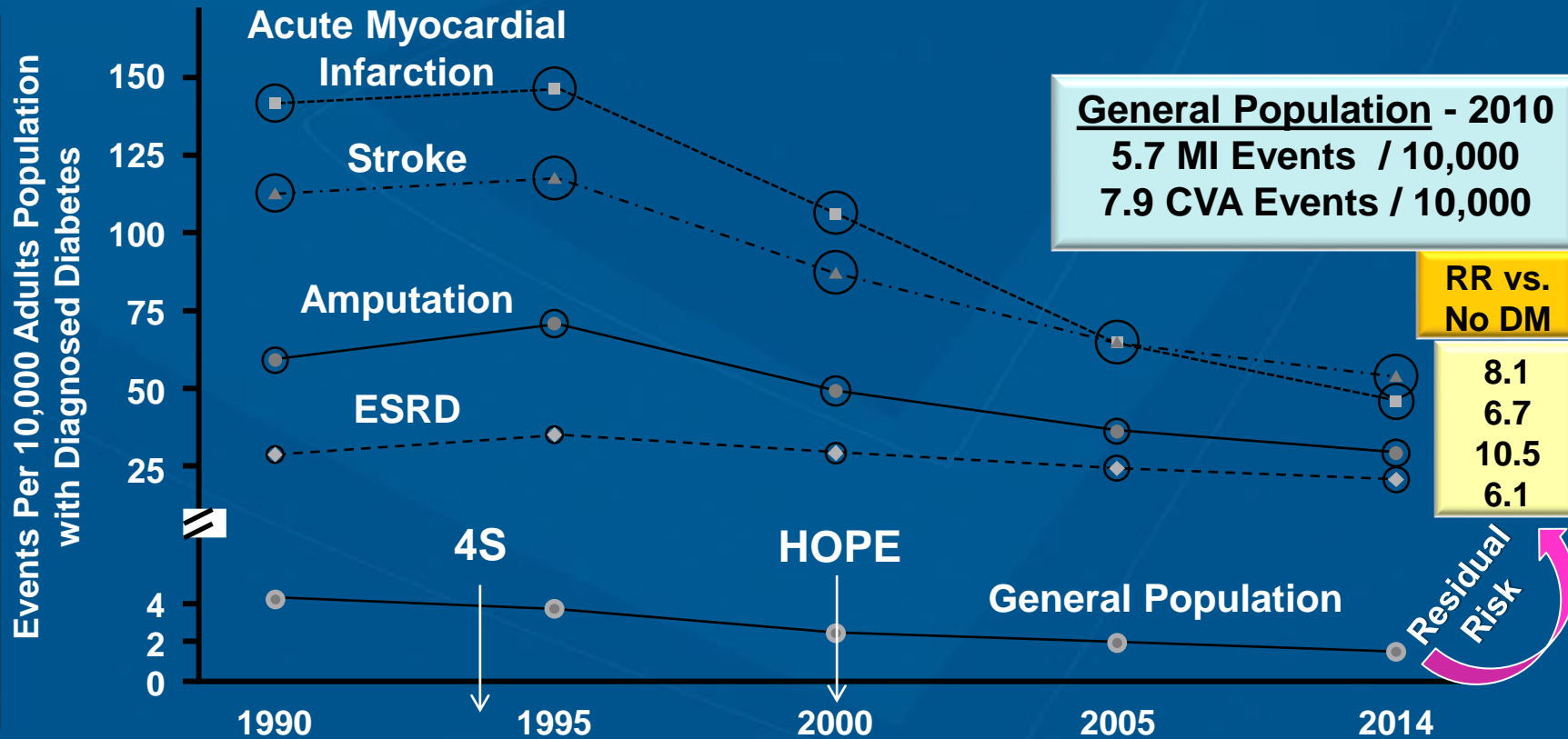


Substantial Reduction In The Rates of DM - Related Complications in the US in Recent Decades...

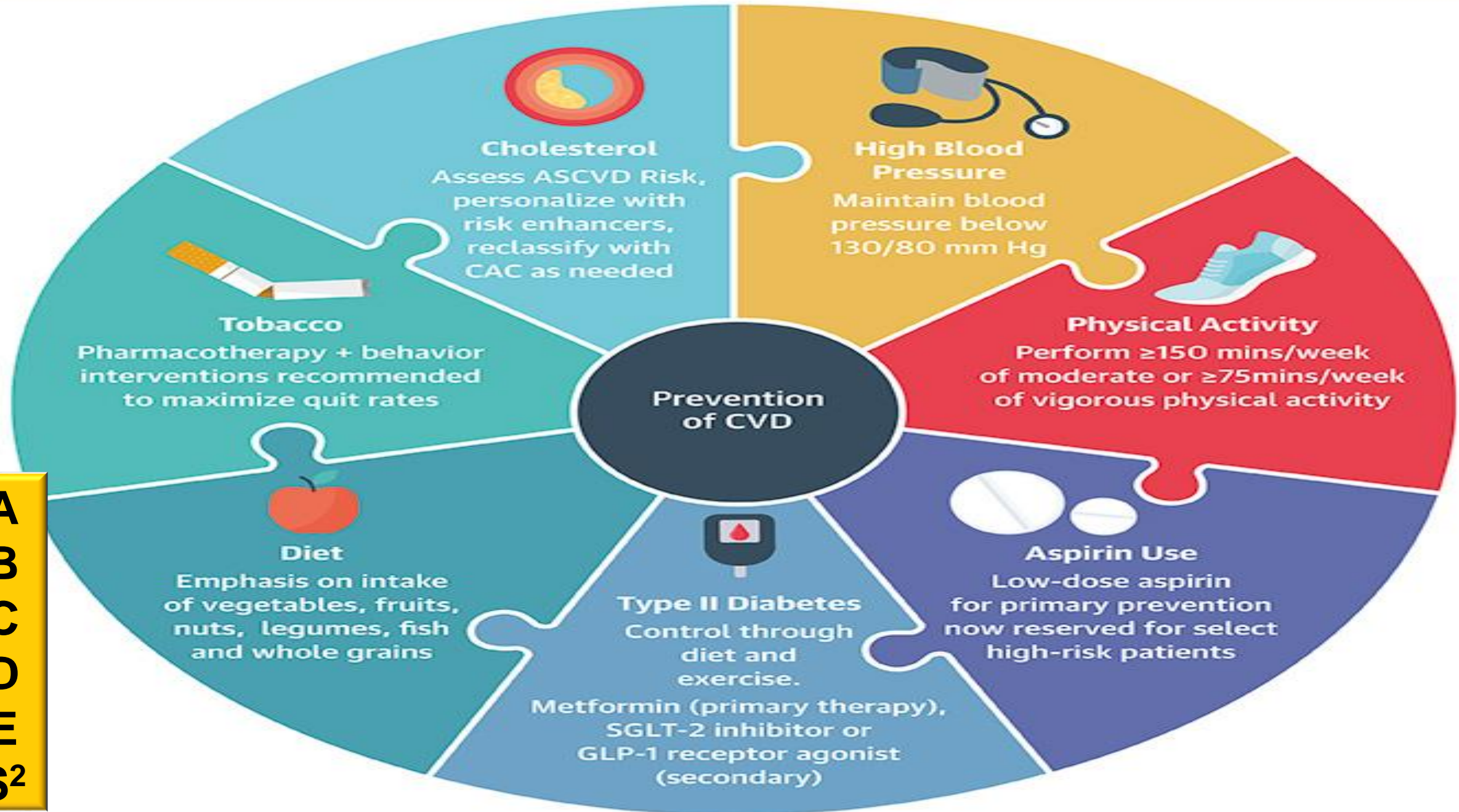
Various US Health Surveys and Data Systems were Used to Compare the Incidences of Diabetes-Related Complications from 1990–2014

**132%
Increase
Risk of CV
Events**

**80%
Increase
Risk All
Cause
Mortality**



...However, a Large Burden Persists... Growing Prevalence of Diabetes. Newer Therapies that Allow Us to Safely Intensify Rx Earlier Should Enable Further Reductions in These Complications...



A
B
C
D
E
S²

Treatment With Standard Of Care Does Not Completely Eliminate CV Risk

Residual CV Risk: The Risk For CV Events Still Remaining After Patients Are Treated With Optimal Standard CV Risk Reduction & T2DM Care, Despite Achievement LDL, BP & Glycemic Goals

CARDS

Atorvastatin vs
Placebo

37% CV Relative
Risk Reduction

5.8% vs 9% That
Experienced A
CV Event

TNT

High Dose vs
Low Dose Statin

25% CV Relative
Risk Reduction
Compared to
Conventional

13.8% vs 17.9%
That Experienced A
CV Event

STENO-2

Intensive vs
Conventional
Therapy

45% CV Relative
Risk Reduction
Compared To
Conventional

65% vs 84% That
Experienced A
CV Event

HOPE

ACE Inhibitor vs
Placebo

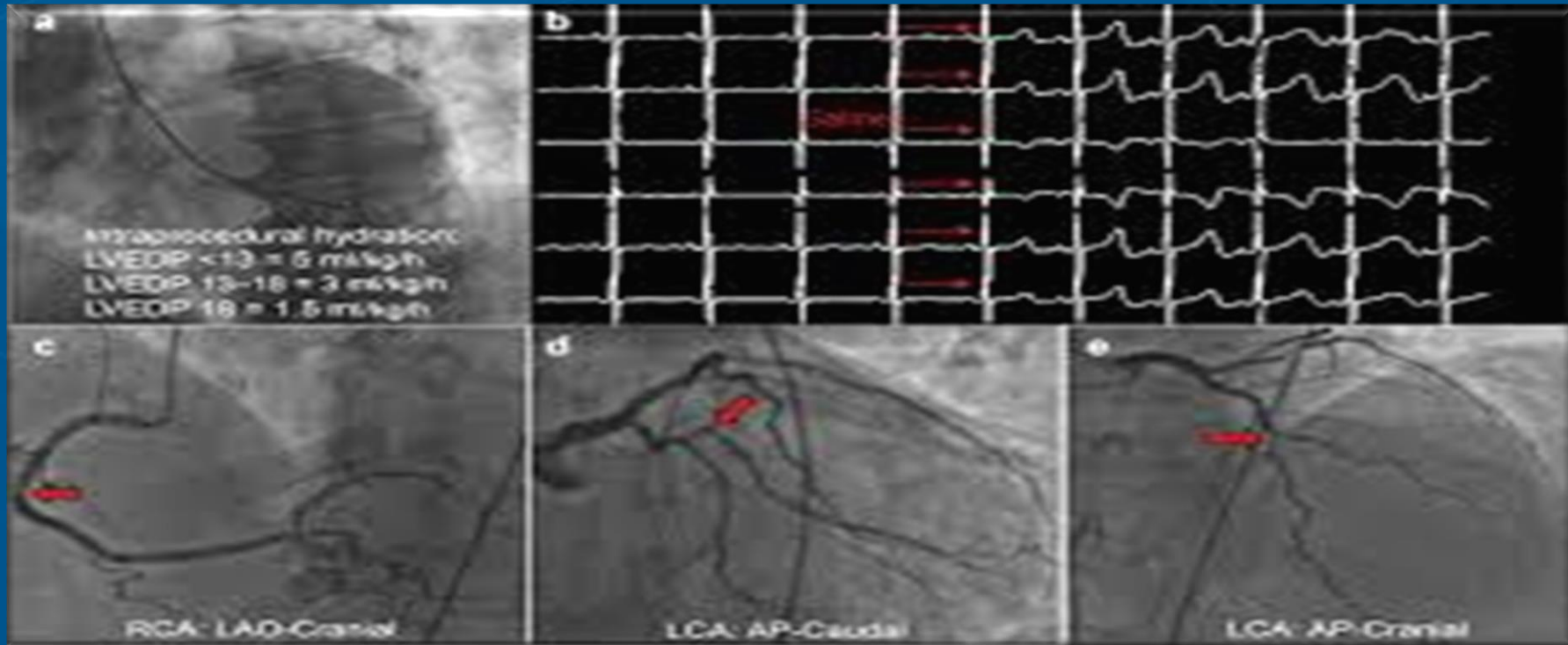
25% CV Relative
Risk Reduction
Compared To
Placebo

15.3% vs 19.8%
Experienced A CV
Event

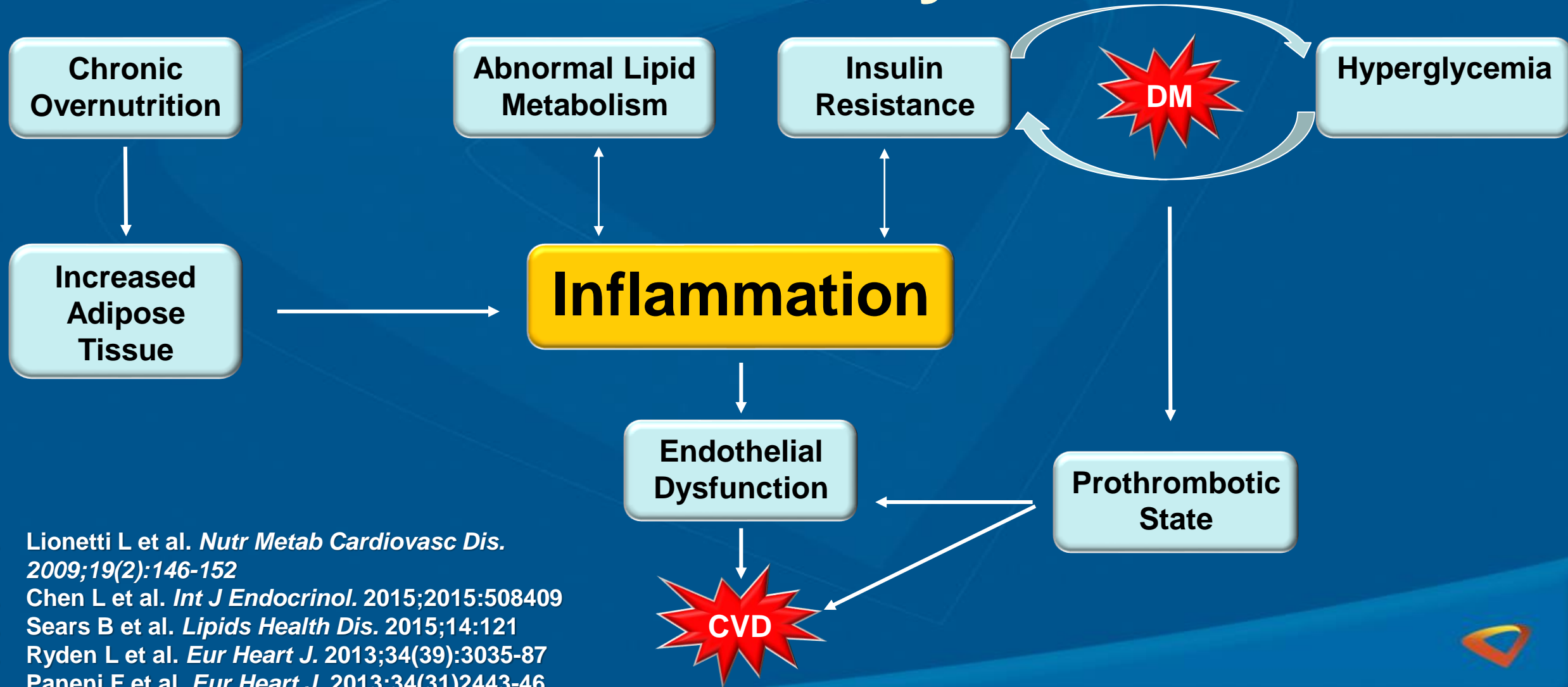
1. Fruchart J, et al. *Cardiovasc Diabetol*. 2014;13(26):2-17.
2. Colhoun HM et al. *Lancet*. 2004;364(9435):685-696.
3. Shepard J et al. *Diabetes Care*. 2006;29(6):1220-1226.
4. Gaede P et al. *Diabetologia*. 2016;59(11):2298-2307.
5. Gerstein H et al. *Lancet*. 2000;355:253-259



How Can T2DM Exacerbate ASCVDz?



These Events Can Be Further Exacerbated By T2DM



1. Lionetti L et al. *Nutr Metab Cardiovasc Dis.* 2009;19(2):146-152
2. Chen L et al. *Int J Endocrinol.* 2015;2015:508409
3. Sears B et al. *Lipids Health Dis.* 2015;14:121
4. Ryden L et al. *Eur Heart J.* 2013;34(39):3035-87
5. Paneni F et al. *Eur Heart J.* 2013;34(31)2443-46

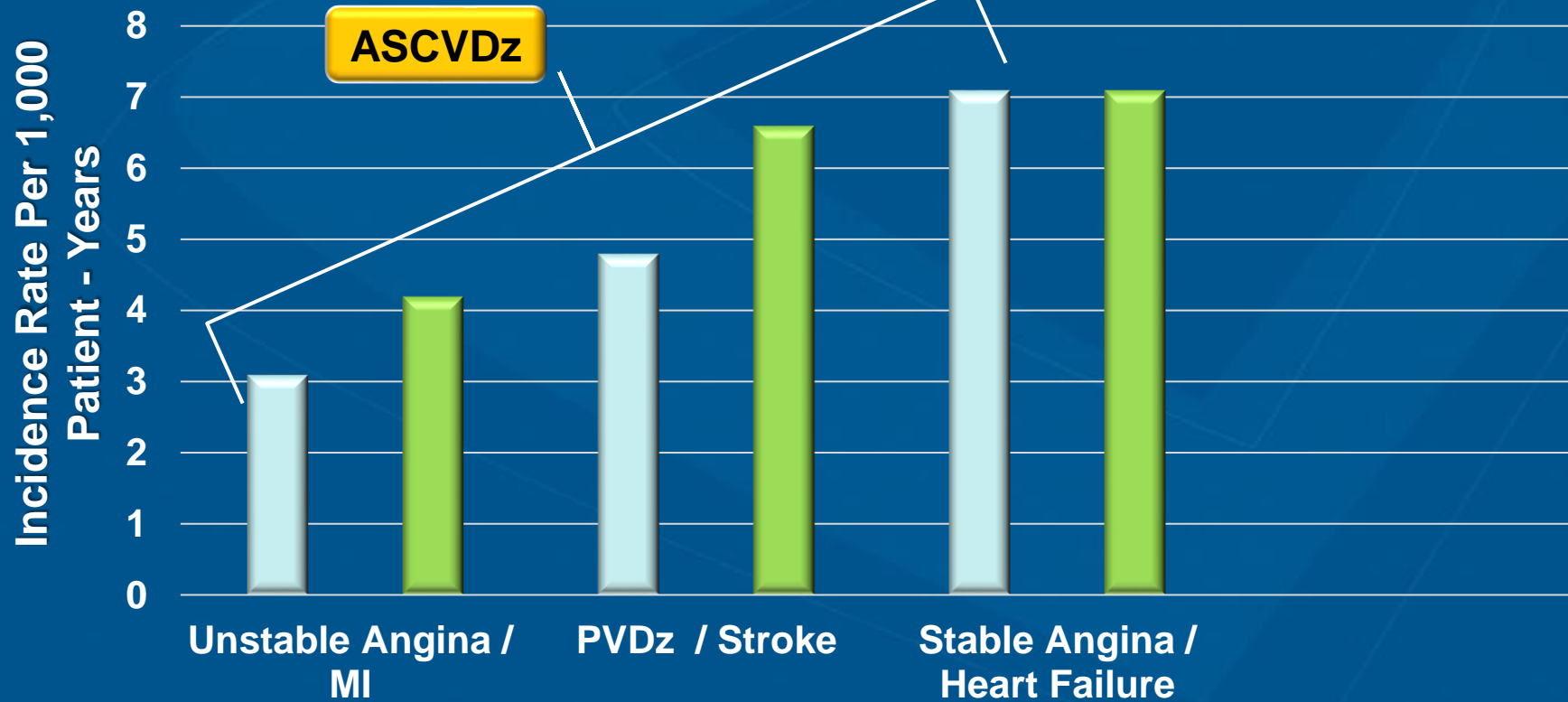


What Is The Most Common Type Of CVDz In Patients With T2DM?



ASCVDz Is The Most Common Form Of CVDz In Patients With T2DM

Retrospective Chort Study (N=135,199)



Combined Incidence ASCVDz 3 Fold Higher Than Heart Failure

Newly Dx T2DM Btw 2003 - 2014

1. An J et al. *BMJ Open Diab Res Care*. 2021;9e001847.
2. Das SR et al. *J AM Coll Cardiol*. 2020;76(9):1117-1145



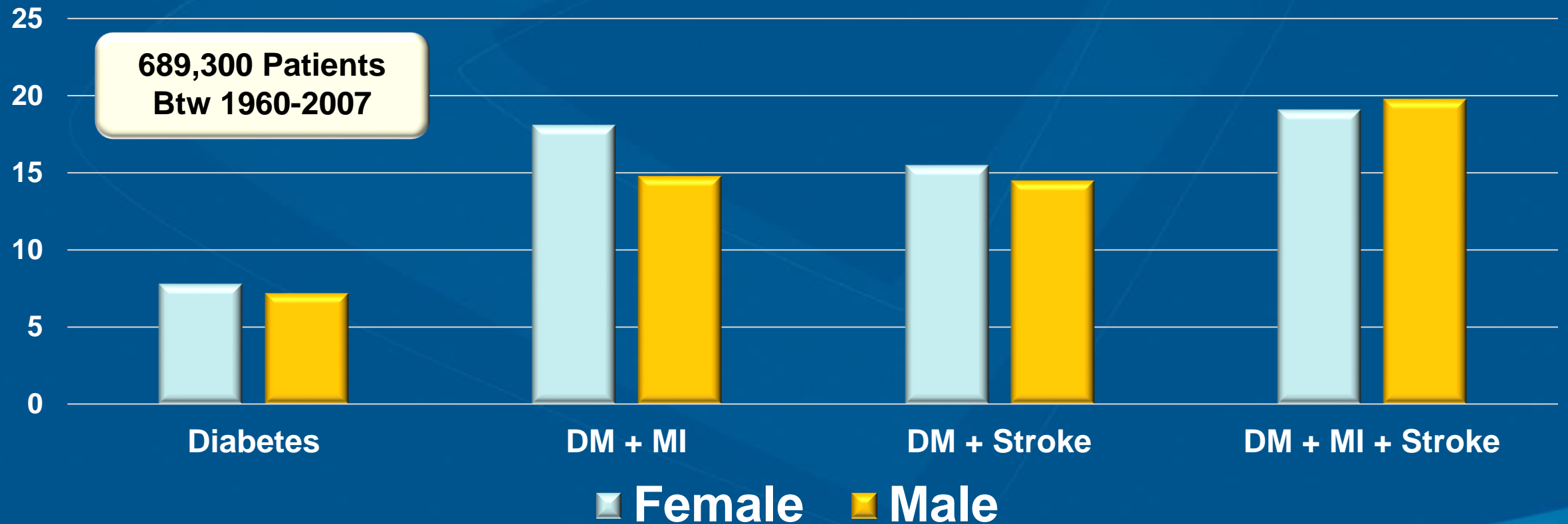
By How Many Years Was Life Expectancy Reduced In Patients Age 50 With T2DM And ASCVD (MI & Or CVA)?

- ▶ According To The Emerging Risk Factors Collaborations Study
 - A. Up To 6 Years
 - B. Up To 9 Years
 - C. Up To 12 Years
 - D. Up To 19 Years



ASCVDz Was Associated With Up To 19 Years Of Future Life Lost

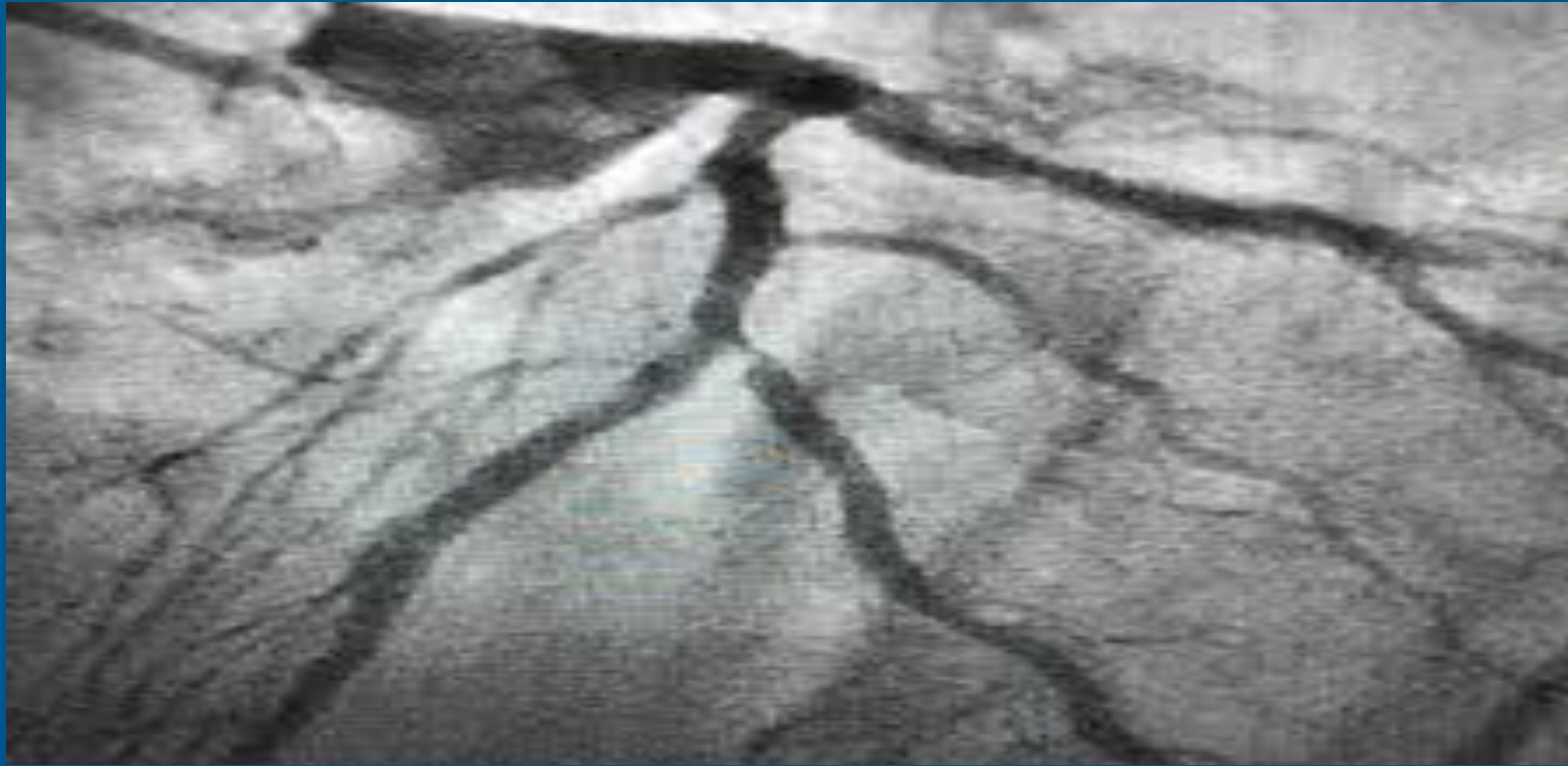
Years Of Life Lost



Emerging Risk Factors Collaboration et al. *JAMA*. 2015;314(1):52-60.
Association of Cardiometabolic Multi-Morbidity With Mortality

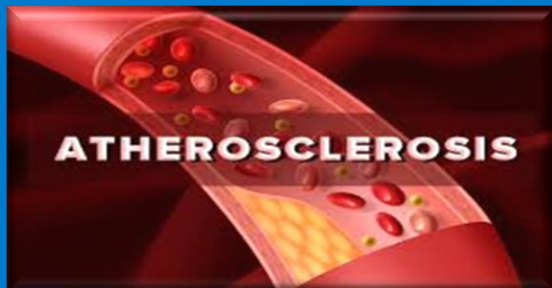


How Does ASCVDz Impact Patients With T2DM?



ASCVDz Is The Number One Cause Of Morbidity & Mortality In Patients With T2DM

ASCVDz Occurs
14.6 Years Earlier
And With Greater Severity
In Patients With T2DM vs
Patients Without T2DM



People With T2DM Have A
2–4 x Higher Risk
of Stroke Or MI vs Those
Without T2DM



1. CDC. <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>.
2. Davies MJ et al. *Diabetes Care*. 2018;31(12):2669-2701.
3. ADA. *Diabetes Care*. 2018;41(5):917-928



Patients With T2DM Are At A Higher Risk of Stroke



Every
2 Minutes
An American Adult
With Diabetes Is
Hospitalized For Stroke

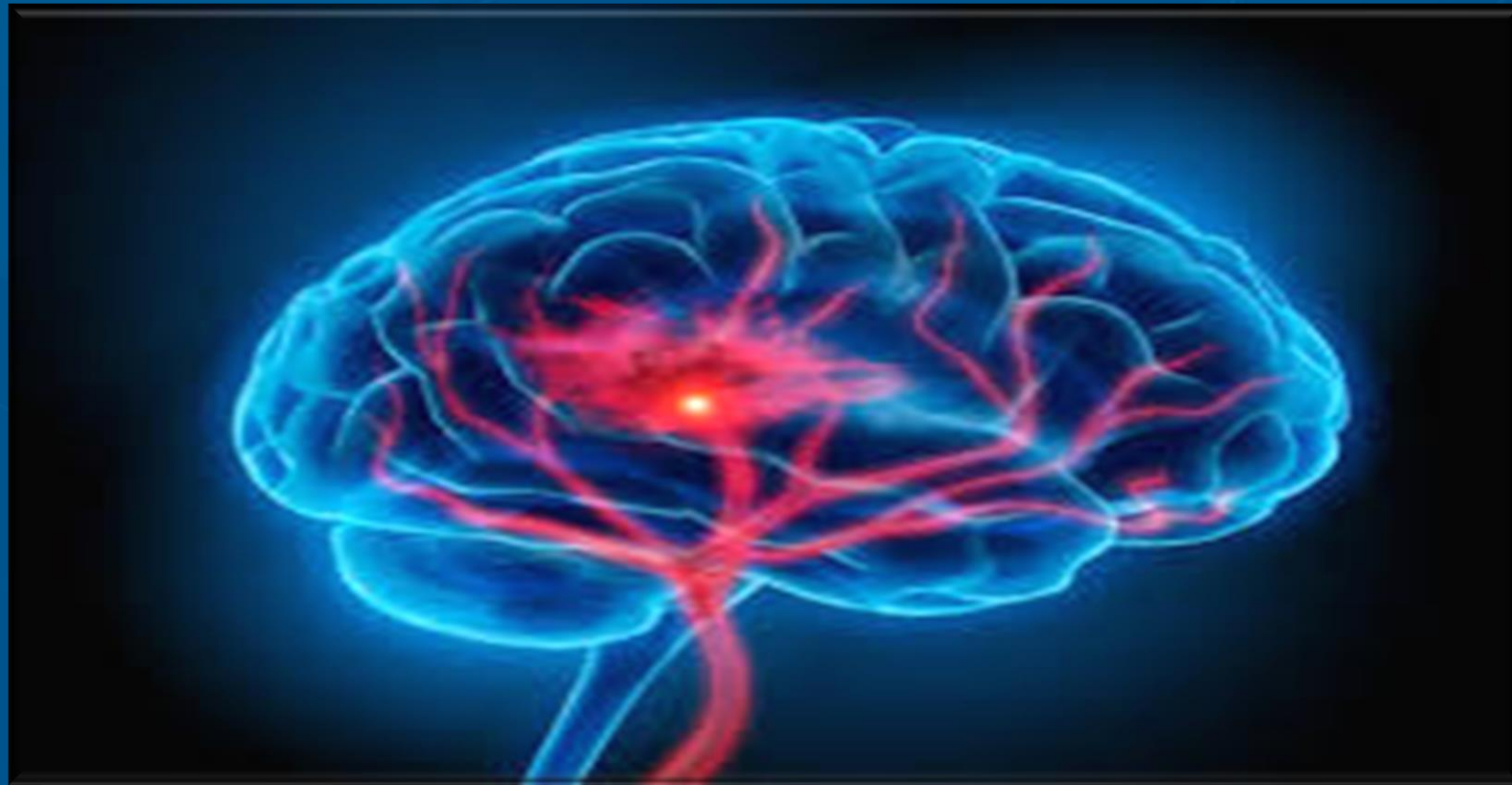


People With T2DM Have A
127%
Higher Risk
Of Ischemic Stroke vs
Those Without T2DM

1. Emerging Risk Factors Collaboration. *Lancet*. 2010;375(9733):2215-2222
2. American Stroke Association. <https://www.stroke.org/en/about-stroke/stroke-risk-factors/diabetes-and-stroke-prevention>

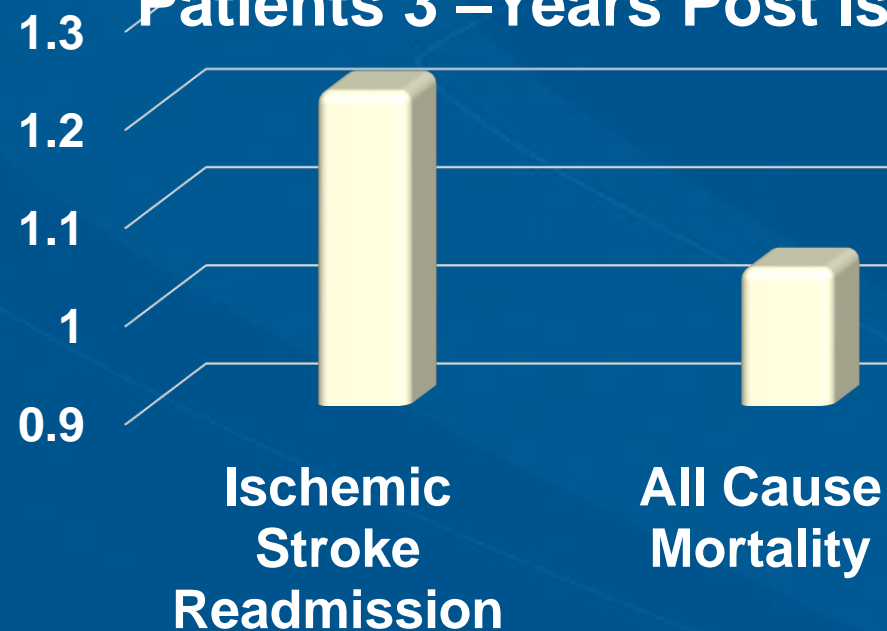


What Are The Differences In Outcomes For Patients With Stroke & T2DM vs Patients With Stroke Without T2DM?



Patients With T2DM Have Higher Mortality, Readmission & Recurrence Post Stroke

Data From Registry Study 409,060 US Patients 3 –Years Post Ischemic Stroke

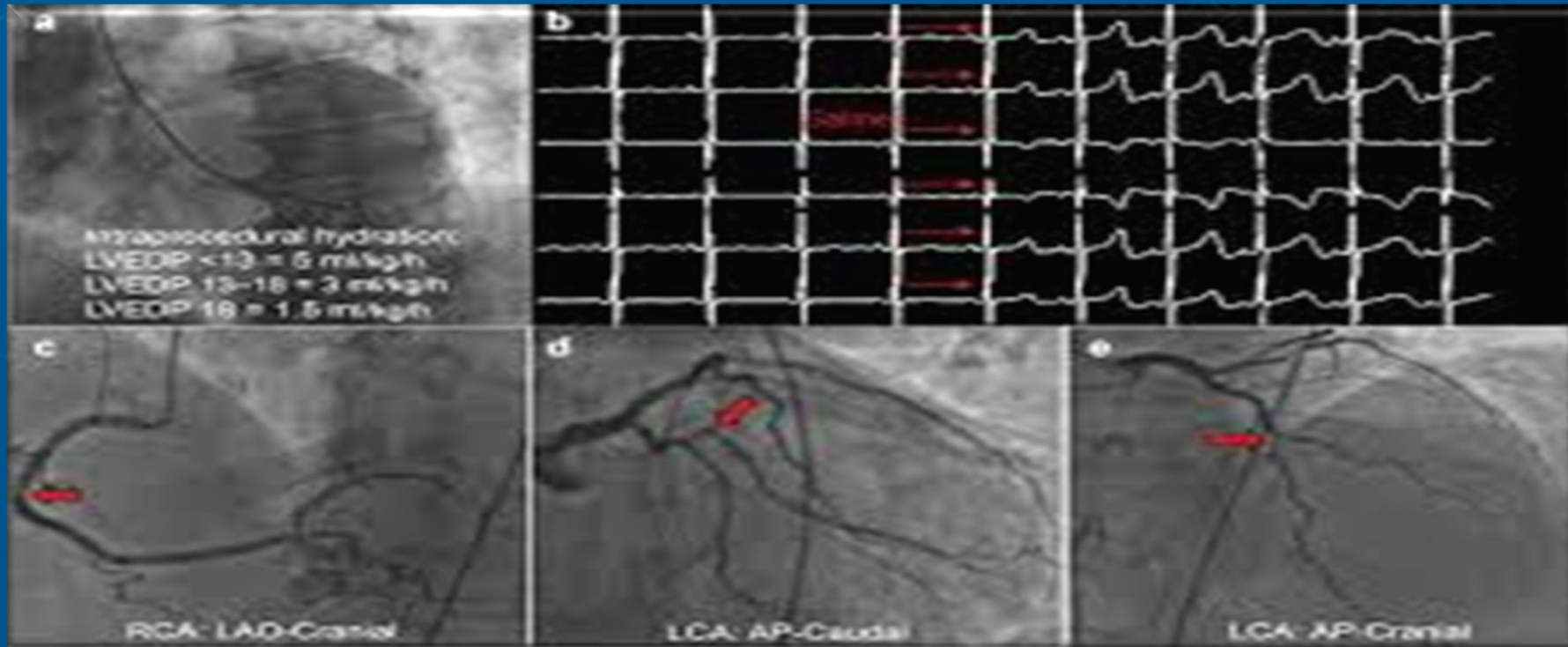


**Higher Readmission Rates
Ischemic Stroke**
(HR, 1.22; 95% CI:1.2,1.24)

Higher All Cause Mortality
(HR, 1.04; 95% CI:1.03,1.05)



What Do The Major Medical Societies Recommend For Patients With T2DM & CVDz?



Major Medical Societies Recommend GLP1-RA Or SGLT-2i With Proven CVDz Benefit For Patients With T2DM & CVDz

2020 ACC

Expert
Consensus
Decision Pathway

- Recommends **GLP1-RA Or SGLT2-i** With Demonstrated CVDz Benefit (Label Indication) As **First Line Options** For Patients With T2DM & Established CVDz

2022 AHA

Scientific
Statement

- Supports Use Of **GLP1-RA & An SGLT2-i** As Antihyperglycemic Therapies Shown To Reduce CVDz Risk In Patients With T2DM

2023 ADA

Standards Of
Medical Care

- Rec: **GLP1-RA** Therapy As The First Injectable Prior To Basal Insulin Use In A Majority Of Pts
- Supports **GLP1-RA** For Patients With A Compelling Need To Minimize Hypoglycemia &/Or Address Weight Concerns

2023 AACE

T2DM
Management
Algorithm

- Recommends A **GLP1-RA Or An SGLT2-i** For Patients With T2DM & Established ASCVDz
Independent Of Glycemic Control



Guidelines Are Evolving To Recommend Therapies That Prioritize CV Risk Reduction in T2DM

2020 ACC Expert
Consensus
Decision Pathway

2023 ADA Standards
of Medical Care in
T2DM

2023 AACE T2DM
Management
Algorithm

In Patients With T2DM & Established ASCVDz, The Use of GLP-1 RA And/Or SGLT-2i With Proven CVDz Benefit (Label Indication) Should Be Considered Independently Of Baseline A1c Or Individualized Targets

The 2023 ADA Standards Of Medical Care In Diabetes Recommends GLP-1 RA And/Or SGLT-2i With Proven CVDz Benefits As Part Of The Glucose Lowering Regimen & Comprehensive CV Risk Reduction In Patients With T2DM & Established CVDz



For The First Time, T2DM Medications With Proven CVDz Benefit Are Recommended In Stroke Prevention Guidelines To Reduce The Risk For Future MACE

The AHA / ASA Guidelines For The Prevention Of Stroke Recommend That:

“In Patients With An Ischemic Stroke / TIA Who Also Have Diabetes, Treatment Of Diabetes Should Include Glucose-Lowering Agents With Proven CV Benefit To Reduce The Risk For Future Major Adverse Cardiovascular Events (ie. Stroke, MI, CV Death)”

A Call To Clinicians For The Use of GLP-1 RA / SGLT-2i With CV Benefit:

“Clinicians Should Now Engage Patients In A Discussion Of New Therapies. Through Shared Decision-Making, Clinicians Should Help Patients Decide If GLP-1 RA / SGLT-2i Are Right For Them”

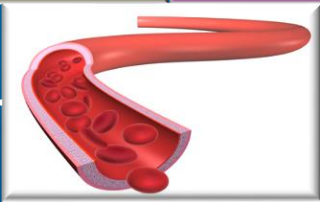


Diversity of Physiologic Effects SGLT-2i & GLP-1RA

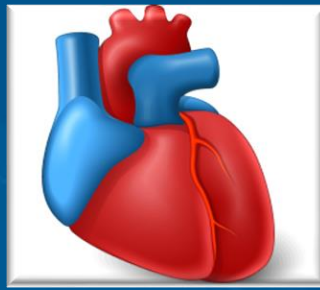
SGLT-2 Inhibitors

GLP-1R Agonists

↓ Sodium Retention / Hypervolemia
RAAS Activation / Neurohormonal
Activation / Inflammation /
Ischemia / Altered Energetics



↑ Vasodilation
↓ Blood Pressure



↑ NO ↓ ICAM-1 / VCAM 1
Improved Endothelial Function

↓ Plaque
Lesion
Burden



↑ Satiety
Nausea

Permeability
TG
↓ Inflammation
Lipid
Deposition

↓ Inflammatory
Pathways in
Plaque



↓ Gastric
Motility

Anti-Atherogenic
Effect



↑ Insulin
↓ Glucagon

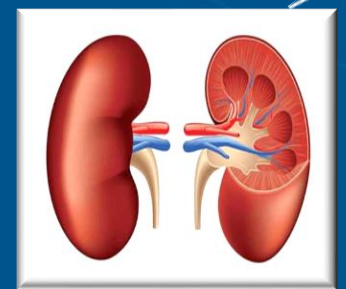
↓ Post-
Prandial
Glucose

Hemodynamic
Effect

↓ Blood Press
Nephropathy
MACE
A1c

↓ Preload
Afterload
Epicardial Fat

↑ Weight
Loss



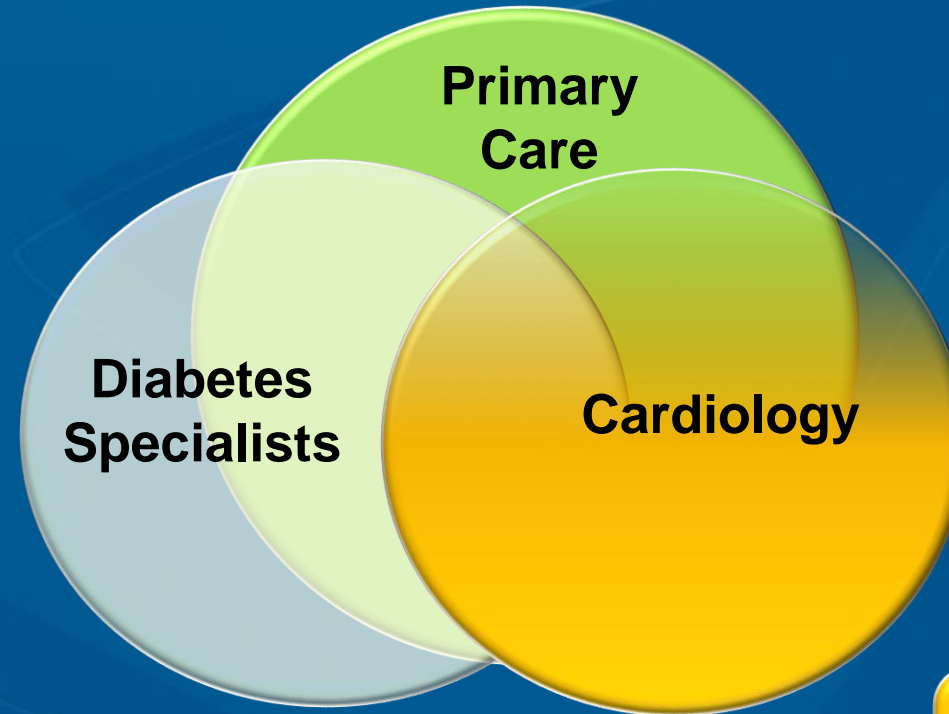
↑ Glucosuria
Natriuresis
Uricosuria

Nauck MA et al. Molecular Metab. 2021; 46:101102
Chad EC. Clin Diabetes. 2014;32(1):4-11



Call For Action To The Cardiology Community

Cardiologists 3 x More Likely Than Endocrinologists To See Patients With T2DM & CVDz



↓ Weight
↑ Physical Activity
Smoking Cessation
Lipid & BP Lowering

Glucose Lowering
SGLT-2i / GLP-1 RA
With Proven CV Benefit

Thrombo-Prevention
Advanced Invasive Therapies
PCI, AICD, CRT



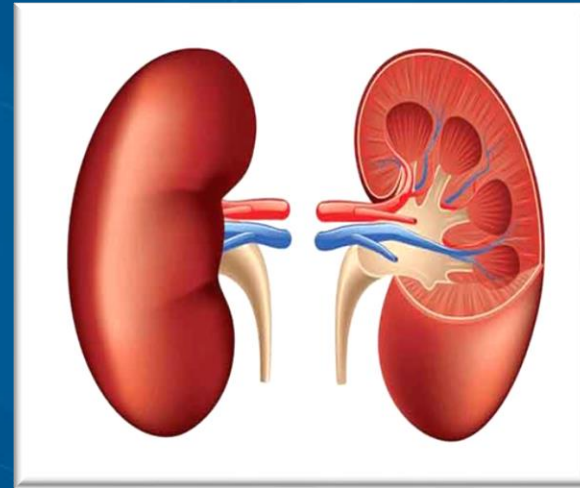
Step 1: Assess CVDz

Presence of ASCVDz, CKDz, HF Compelling Indication

**ASCVDz
Predominates**



**HF Or CKDz
Predominates**



Glucose Lowering T2DM: Overall Approach

ASCVDz Predominates



**GLP-1 RA With Proven CV
Benefit**

**Either
Or**

**SGLT-2i With Proven CV
Benefit If eGFR Adequate**



Glucose Lowering T2DM: Overall Approach

HF Or CKDz Predominates



Preferably: SGLT-2i With Evidence Reducing HF and/or CKDz Progression in CVOTs if eGFR Adequate

Or

SGLT-2i Not Tolerated / Contraindicated, Add GLP-1 RA With Proven CV Benefit



SGLT2i Meta-Analysis

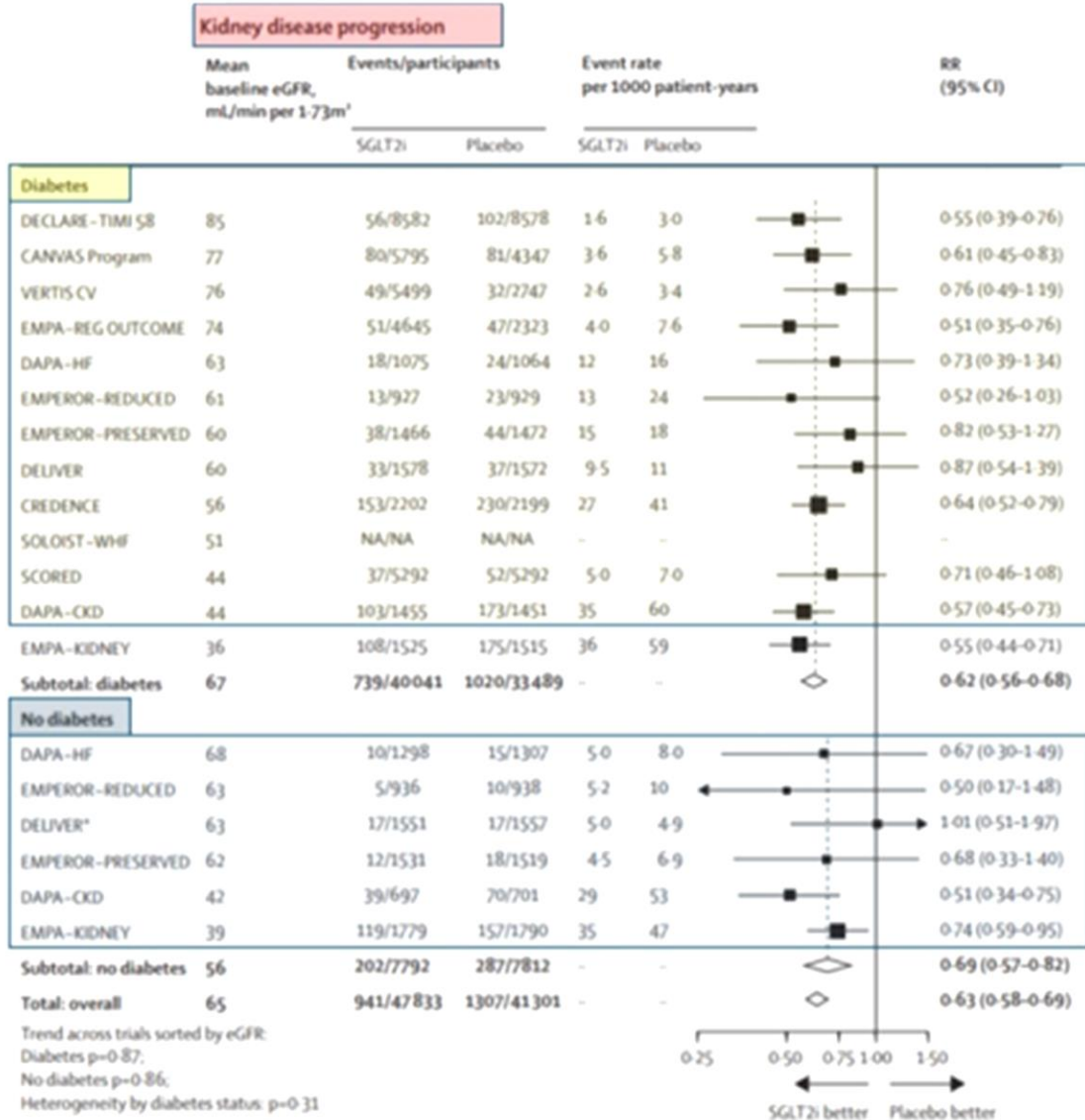


Table 1 Effect of SGLT2 inhibitors on clinical outcomes in adults with diabetic kidney disease

Outcome	No. studies	No. events	Sample size	HR (95% CI)
MACE	6	2271	21,913	0.83 (0.75-0.93)
Kidney composite	5	1197	21,195	0.66 (0.58-0.75)
HHF	6	1219	22,346	0.62 (0.55-0.71)
Cardiovascular death	5	953	20,539	0.84 (0.74-0.96)
Fatal and nonfatal MI	5	498*	20,108	0.78 (0.67-0.92)
Fatal and nonfatal stroke	5	332*	20,108	0.76 (0.59-0.97)
All-cause mortality	5	1451	21,406	0.86 (0.77-0.96)

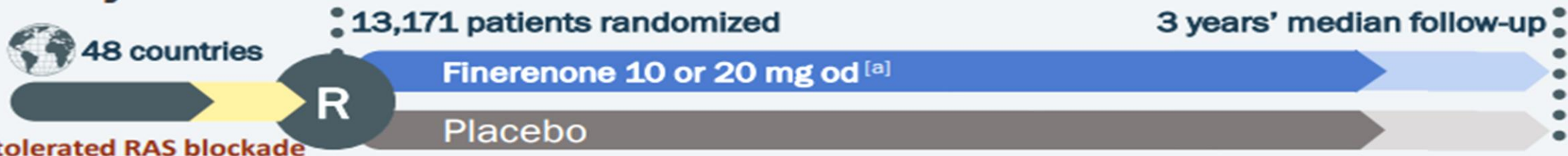
Meta-Analysis of 13 SGLT2i Trials

- Data Analysis of 13 SGLT2i Trials Involving 90,000 Participants With & Without Type 2 Diabetes Or At Risk for CVD, HF, CKD.

Main Safety: 2.12 RR Ketoacidosis T2DM on SGLT-2i, Amputation 1.06 RR (95% CI, 0.93 – 1.21)

Fidelity Summary & Conclusions

FIDELITY is a large individual patient data pooled analysis of FIDELIO-DKD [1] and FIGARO-DKD [2]



Key eligibility criteria

- ✓ T2D
- ✓ CKD
- ✓ On single RASi
- ✓ Serum [K⁺] ≤4.8 mmol
- ✗ Symptomatic HFrEF

		UACR (mg/g)		
		0-29	30-299	≥300-≤5000
GFR (ml/min/1.73 m ²)	>90			
	60-89			
	45-59			
	30-44			
	15-29			

Key outcomes

CV composite

Time to CV death, nonfatal MI, nonfatal stroke, or HHF



57% eGFR kidney composite

Time to kidney failure,^[b] sustained ≥57% decrease in eGFR from baseline, or renal death



- Significant Reduction Incidence of hHF / New - Onset AF
- Modest BP Effects (3.7 mmHg)
- Manageable Increase Hyperkalemia w Minimal Clinical Impact



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Diabetes Research and Clinical Practice

journal homepage: www.journals.elsevier.com/diabetes-research-and-clinical-practice



Cardiovascular and kidney outcomes of combination therapy with sodium-glucose cotransporter-2 inhibitors and mineralocorticoid receptor antagonists in patients with type 2 diabetes and chronic kidney disease: A systematic review and network *meta*-analysis

36,186 Patients. Meta-Analysis. Combination of SGLT-2i's + MRA's Reduced Composite CV / Renal Events With Less Hyperkalemia Compared to SGLT-2i's or MRA's Alone



Cornerstone Treatments Diabetic Kidney Disease

Risk Factors Management:

- Plasma Glucose
- Blood Pressure
- Weight Control
- Smoking Cessation
- Lipid Control
- Physical Activity

ACEi/ARBs

Captopril
IDNT
RENAAL

ACE / ARB
Max Tol
Dose

SGLT2i

CREDENCE
DAPA-CKD
SCORED
EMPA -
Kidney

Now

MRAs

FIDELIO-DKD
FIGARO-DKD

New

GLP-1 RA

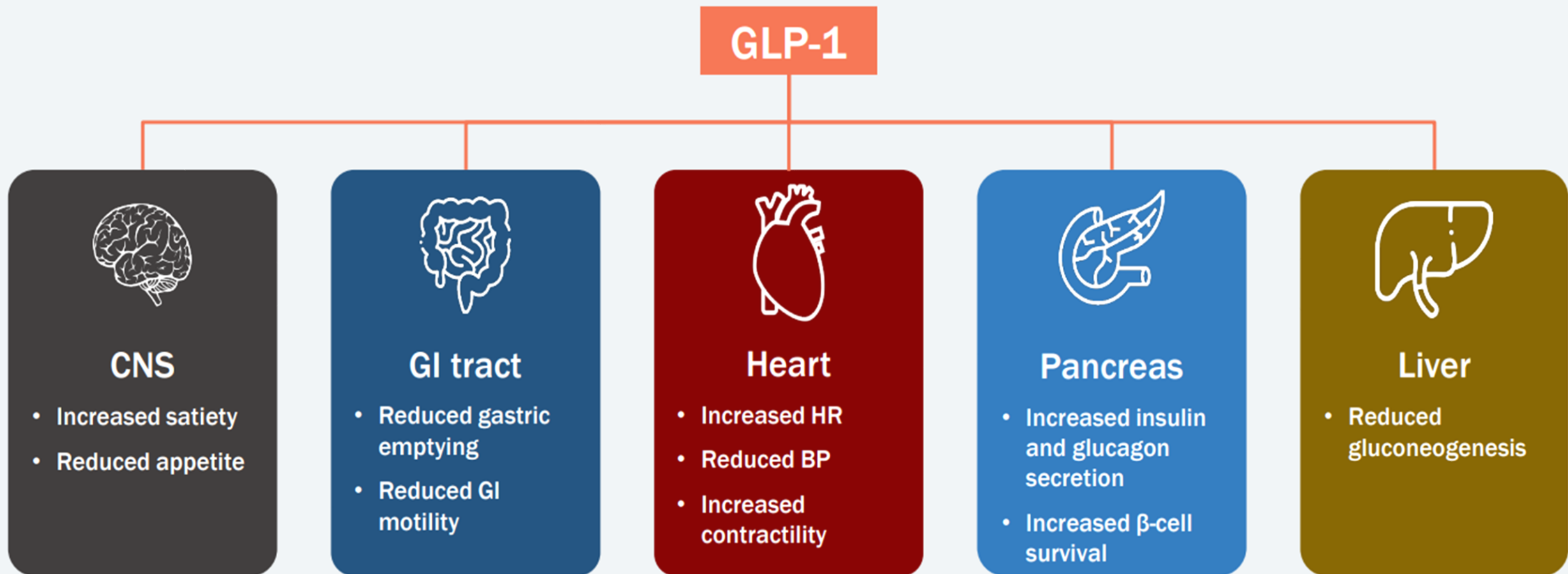
FLOW

Next?

Lewis et al., NEJM 1993, Lewis et al., NEJM 2001, Brenner et al., NEJM 2001, Perkovic et al., NEJM 2019, Bhatt et al., NEJM 2021, Bakris et al., NEJM 2020



GLP-1 RA Benefits Extend Beyond MACE Reduction



0.89, $P < 0.0001$).

August 14, 2019 DOI: [https://doi.org/10.1016/S2213-8587\(19\)30249-9](https://doi.org/10.1016/S2213-8587(19)30249-9)



The rationale, design and baseline data of FLOW, a kidney outcomes trial with once-weekly semaglutide in people with type 2 diabetes and chronic kidney disease

Background

Evidence has emerged of potential kidney-protective effects of GLP-1 RAs in people with T2D. FLOW is a dedicated kidney outcomes trial to assess semaglutide in a population with CKD and T2D at high risk of kidney disease progression.

Methods

Participants:

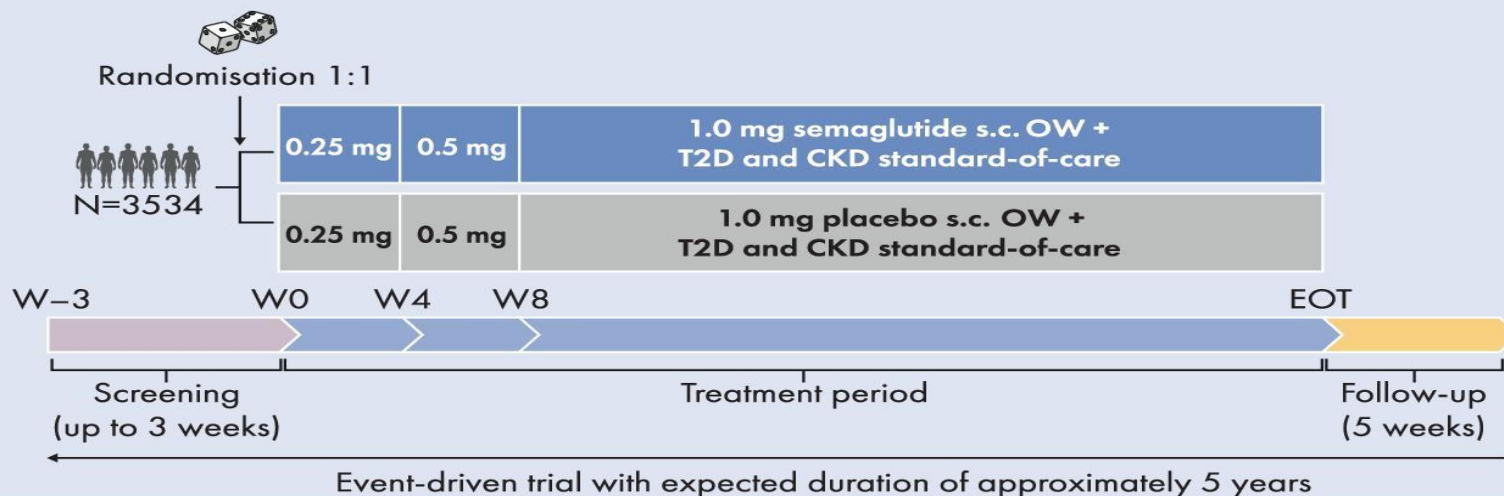


- Adults with T2D
- eGFR ≥ 50 to ≤ 75 ml/min/1.73 m² and UACR >300 to <5000 mg/g OR
- eGFR ≥ 25 to <50 ml/min/1.73 m² and UACR >100 to <5000 mg/g

Composite primary endpoint:



- Time to first occurrence of:
- Kidney failure (persistent eGFR <15 ml/min/1.73 m² or initiation of CKRT);
 - Persistent $\geq 50\%$ reduction in eGFR; or
 - Death from kidney or CV causes



Baseline characteristics



68.2% at very high risk for CKD progression according to KDIGO categorisation, eGFR of 47.0 (15) ml/min/1.73 m²; median UACR of 568 (range: 2–11 852) mg/g



Advanced type 2 diabetes:

Mean age 66.6 years
Mean diabetes duration 17.4 years
Mean HbA_{1c} 7.8%



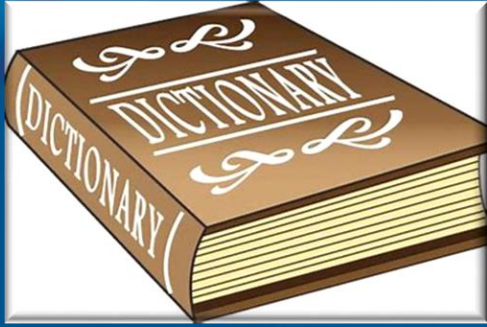
15.5% receiving SGLT-2is

CKD, chronic kidney disease; CKRT, chronic kidney replacement therapy; CV, cardiovascular; eGFR, estimated glomerular filtration rate; EOT, end of treatment; GLP-1RA, glucagon-like peptide-1 receptor agonist; HbA_{1c}, glycosylated haemoglobin; KDIGO, Kidney Disease: Improving Global Outcomes; OW, once weekly; s.c., subcutaneous; SGLT-2i, sodium-glucose cotransporter-2 inhibitor; T2D, type 2 diabetes; UACR, urine albumin-to-creatinine ratio; W, week.

Conclusion

FLOW will evaluate the effect of semaglutide on kidney outcomes in participants with CKD and T2D, and is expected to complete in late 2024.

What Is The Enemy? Winning The WAR



Clinical Inertia: (Noun) A Tendency To Do Nothing Or Remain Unchanged. Failure to Initiate / Intensify Rx Where A Patient's Health Would Likely Improve By Such. Synonyms: Inactivity, Inaction, Inertness, Passivity

He / She
Has 'Mild'
Diabetes

Why
Should I
Change
Anything?
...Doing
Fine

My Patient
Is Stable
On Current
Therapy

More
Work For
Me

Inconvenient
For Him / Her

'Clinical Trials & Drug Discovery Are Only Part of the Overall Solution. The Knowledge Gained Needs to be Translated into Patient Care—Something We Have Done Poorly With ARNIs, a Class of Agents with a 20% Reduction in Mortality. If We Are to Win the War Against Cardio-Renal- Metabolic Syndrome, Science Will Need to be Coupled With Pragmatic & Deliberate Implementation Approaches With the Goal of Overcoming Inertia'

Think About Ways To Overcome Clinical Inertia As One Of Our Biggest Impediments In Knowledge Translation

**Any
Questions?**



“Traditional Wisdom is Short on Wisdom and Long on Tradition”

Mark Twain

“We Can’t Solve Problems Using the Same Kind of Thinking We Used When We Created Them.”

Albert Einstein



